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Presidential Address

Delivered at the Annual Meeting of the Manitoba Medical Association, October 20th, 1948, by Dr. Roy W. Richardson, Retiring President

There are many current topics which could be ed this year for the Presidential Address. Some these are contained in the Annual Reports and ll be discussed during the meeting. As a mem- of the Executive for the past few years, several periences have shown the subject I have chosen be important to us at this time. I propose that u consider with me "Medical Organization in anitoba."

There was a time when the deliberations of edical associations were devoted almost entirely the circulation of medical lore. Recently, how- er, governments have become more and more volved in health matters and the doctor finds mself in contact with public bodies. The state s been given a tremendous impetus in community alth planning by the demands of the public. Our ofession must be prepared to guide that planning. e require a united profession, with a competent ganization, if we are to make our efforts effec- ve. It is necessary, then, that we examine the edical set-up in this province.

Upon becoming a new member of the Executive ree years ago I was, first of all, amazed at the mber and diversity of problems that confronted e profession. Many of these could not wait over the opinion of an Annual Meeting and, of cessity, became the responsibility of your elected uncil. Fortunately, your Executive is broadly presentative of all branches of the profession and animity of opinion is easily attained.

The second shock came to me, as a new Execu- ve member, when it was realized that in the ovince there was more than one organization presenting the profession. Each was capable of rming a somewhat different opinion and of pro- aiming that opinion when invited to do so by e government, or other agencies.

In Manitoba, we have the College of Physicians nd Surgeons, the Manitoba Medical Association, e Faculty of Medicine, the District Medical ocieties, including the larger Winnipeg Medical ociety, and the recently formed General Prac- ioners' Association. The M.M.A. embraces all these as affiliated groups, with the exception of e C.P. & S. and the Faculty of Medicine. In atters of policy, one suggests that the Manitoba edical Association should always be the final ody for consolidating the opinion of its affiliated roups, and it should be the only disseminator of eir combined decisions.

It has happened that some affiliated sections, or special groups, have made private arrangements with such bodies as the Workmen's Compensation Board and the Department of Veterans Affairs. One suggests again, that these negotiations should always be made by, or through, the parent association.

The Faculty of Medicine is in a different category. It is concerned with medical education and is controlled by the University. By necessity, it may view issues in a different light to that of the practitioner. However, many of its members are practitioners and nearly all belong to our Association.

The principal organizations which formulate the policies of the profession are the C.P. & S. and the M.M.A. Let us outline how they differ in structure!

The College of Physicians and Surgeons receives its authority from the Povincial Medical Act and its duties and responsibilities are laid down by law. It has control over licence and discipline. The policy affecting licence to doctors from outside our Dominion has become an urgent concern of the profession. C.P. & S. membership is compulsory for a practitioner. The Council is elected by all those registered in the province. Receiving its authority by an Act of the Legislature, it is subject to the will of government, who can change that authority, should it so desire.

The Manitoba Medical Association is a voluntary body. The officers are elected by its members. Its Aims and Objects are to enable the medical profession of the province to fulfil, by co-operation and unified action, those responsibilities to society which its members cannot meet by individual action alone. Besides advancing medical knowledge and promoting professional attainment, it is the forum for discussion and crystallization of medical opinion.

It is to be noted, that both organizations comprise the same members of the profession. In some provinces these two bodies are combined under a Legislative Act. This has the advantage of having one compulsory membership fee and one congress. This may be desirable in ordinary times with, what might be termed, a sympathetic government. In this province, in the near future, being a voluntary body, we may find ourselves more free to function uninhibited by legislative authority. It would seem, then, to our advantage to continue with two

separate organizations. We must exercise great care that we do not disunite ourselves, or present two separate policies on any question, nor must we allow ourselves to be played one against the other.

To illustrate the inefficient manner in which we express our views, we might use as an example the Special Select Committee of the Legislature on Health, two years ago. The M.M.A. was invited by the government to present a brief at this conference. A similar request was received by the C.P. & S. Both presented a separate brief, yet each represented the same members of the profession. The Faculty of Medicine also presented a brief. Fortunately, there was no great divergence of judgment, but this could happen, with disastrous consequences, as it would be an opportunity for the government to disregard, what would be considered by them, a divided profession that could not agree on a solution.

In reviewing the situation, the need seemed to be (1) to agree on what we might call the sphere of influence of each, (2) to have a closer liaison, or an interlocking directorate. It is gratifying to be able to report the progress that has been made in this direction.

Your Executive took the initiative and invited the C.P. & S. to appoint a liaison committee to meet us. It was apparent that the C.P. & S. was most anxious to co-operate and that we could arrive at similar decisions when all the facts were known to both. Any previous misunderstanding had been due to each working separately.

Early this year the Registrar of the College retired, due to ill health, and the liaison committee recommended that this office be conjoined with that of our Executive Secretary. The C.P. & S. Council concurred. At present we have a combined office and staff, which has made for greater efficiency and economy. All the business of the profession passes through the office of the Registrar-Secretary, who is able to properly assign the subject, keep both councils informed, and prevent overlapping and misconception. It is a full-time position. This is a fitting occasion to commend Dr. M. T. Macfarland for his most excellent work. We are fortunate to have acquired his services. The relations of the College and Association have never before been so harmonious. Our aim is, that each should have a clear idea of the scope of its responsibilities and that each should negotiate on these alone.

There are two representatives from the C.P. & S. on our Executive at present. They can keep the Council informed of our decisions but they may not be able to induce a similar opinion in the Council, who have not heard our full discussion. Since the electorate is the same for both College and Association and, in order to make certain that we do not have two spokesmen of different opinions on any future medical question, I would recommend that we create means to have a larger number of councillors common to both executives. This would be possible with a change in the electoral system of both College and Association, a change which seems long overdue. Such an innovation on the part of the College would require opening the Medical Act, which may not be propitious at this time.

Until this can be done, some progress can be made if all nominating committees and voters keep this objective in mind. There seems no reason why the District Medical Societies should not elect their incumbent C.P. & S. councillors as their representatives to the M.M.A. Executive, or vice-versa. The same procedure could be followed in the election of Members-at-Large to the M.M.A. Executive. By this method alone, we could be assured of sufficient interlocking of the two Councils.

Our challenges in the past have been important, but I believe we will soon be called upon to make even greater decisions which will affect medical practice for many years. We must be certain that we have an integrated organization to meet these new problems. We must have one spokesman for a united profession!

PAEDIATRICS

Edited by S. Israels, M.D.

At a meeting in the Medical Arts Club Rooms on August 12, 1948, the Pediatrics Section of the Winnipeg Medical Society was reorganized. Dr. Jos. Graf was unanimously elected the new President of the group and Dr. Sydney Israels was named as its Secretary-Treasurer.

The aims of the section are to promote better pediatrics in the city and to provide through the meetings a social get-together of the pediatricians. It was decided that meetings would be held in October, November, January and February of each year.

The second meeting of the group was held in the Medical Arts Club Rooms on October 9, 1948, when the Society was host to Professor Irvin McQuarrie of the University of Minnesota. Following a dinner at the Club, Prof. McQuarrie addressed the Winnipeg Medical Society on "Recurrent Convulsions in Childhood."

Highlights of Prof. McQuarrie's Talk to the Winnipeg Medical Society on Convulsive Disorders of Childhood

Professor I. McQuarrie, who is head of the Pediatrics Department at the University of Minnesota, addressed the Winnipeg Medical Society on "Convulsive Disorders of Childhood" on October 9, 1948. He has kindly permitted us to publish the highlights of his address here.

The speaker laid emphasis in his opening remarks on the frequency of convulsions in childhood and on the repercussions of such seizures on the parents and relatives of the child. Not only is the convulsive episode itself alarming and ominous but the "stigma" attached to the family is one of the condemnations of our society. We realize that many of the world's great men suffered from recurrent seizures, and yet we know that families will do everything in their power to conceal such a disability in one of its members. This calls for a re-education of physicians on this matter and education of the public on their orientation toward this disease. The speaker made the point of how people with recurrent seizures suffer not only that disability, but also that of being shunned by his fellow-men.

The second point brought out was the fact that the seizure in itself is only a symptom and requires thorough investigation of its cause. In cryptogenic epilepsy it is the main feature of the disease but in epilepsy simulating states it is only one of the symptoms and signs. Cryptogenic (idiopathic) epilepsy remains the diagnosis only after all other "organic" causes are excluded. To illustrate this, the speaker showed slides showing the findings in toxoplasmosis, cerebral agenesis, Sturge-Webers syndrome with intracranial calcification—all as an underlying cause of recurrent convulsive seizures.

The recurrent convulsive disorders were classified as follows:

(1) Idiopathic (Primary, cryptogenic) Epilepsy.
  (a) Hereditary of genetic.
  (b) Non-genetic or acquired idiopathic.
(2) Organic (Secondary of symptomatic) Epilepsy.
  (a) Post-traumatic.
  (b) Post-hemorrhagic.
  (c) Post-anoxic.
  (d) Post-toxic (Kernicterus, lead poisoning).
  (e) Degenerative—Brain disease.
  (f) Congenital—porencephaly, Sturge-Webers disease.
  (g) Intracranial neoplasm.
  (h) Parasitic brain disease.
(3) Epilepsy-simulating diseases.
  (a) Hysteria.
  (b) Tetany.
  (c) Hypoglycemia.
  (d) Uremia.
  (e) Cardiovascular dysfunction as in Stokes-Adams disease.

The incidence of each of these types of disorder at the various ages in children was stressed. For example, whereas cerebral trauma is a major cause of convulsions in a newborn, tetany infection and cryptogenic epilepsy are rare. However, by the age of two years infection becomes a major cause of seizures, while at the age of 10 years idiopathic epilepsy is the prime cause.

The speaker then referred to the various diagnostic methods in use, stressing the growing importance of the electroencephalograph. He appeared to subscribe to the concept of Lennox and Gibbs that the electroencephalographic pattern differed in petit mal, grand mal, and psychomotor attacks, although later in the discussion he said that he felt that these were all primarily the same disease. In addition to an accurate history, a thorough physical examination, and an electroencephalogram, Dr. McQuarrie felt that air studies were often necessary to settle the diagnosis. He did not subscribe to routine air studies in all cases.

Next he turned to some interesting experimental work he was doing in an attempt to elucidate the mechanism of recurrent seizures. He showed studies in animals on the effects of hypo-

glycaemia, anoxia, or both in the production of convulsions. In addition he was able to demonstrate that hypopotassemia favored a diminution in convulsive seizures in animals. The mode of action of the potassium depletion was not known. It was felt that the potassium ion was in some way related to nervous irritability via acetylcholine and that high potassium may catalyze choline acetylase activity and so promote more acetylcholine formation or inhibit cholinesterase and so allow more acetylcholine to remain in nervous tissue, so affecting nerve irritability. In any case, he was able to show a case where a young man, not helped by any other means, was kept symptom-free for some time by the use of desoxycorticosterone pellets and had recurrence of seizures when the medication was withdrawn. Dr. McQuarrie also indicated that states which increase cell membrane permeability also increase seizures. The speaker illustrated the effect of hydration in producing seizures experimentally.

In the treatment of cases of recurrent seizures the efficacy of the ketogenic diet, of starvation and of dehydration were demonstrated. The use of drugs such as dilantin, phenobarbital, mesantoin and Tridione were reviewed. However, the speaker emphasized the necessity of close study of the etiology and then the management of the patient as a whole in controlling his seizures.

S. Israels.

Hypopotassaemic States

This address was given at the luncheon at the Children's Hospital on October 10, 1948, by Dr. I. McQuarrie and is abstracted with his kind permission.

The speaker drew together under the above title, the following entities.

(1) Familial periodic paralysis.

(2) Cushing's Syndrome.

(3) Acute Infantile diarrhea.

(4) State resulting from the treatment of diabetic coma with carbohydrate saline and insulin.

(5) Chronic alkalosis resulting from diarrhea in childhood. (Case of Dr. D. C. Darrow).

(6) Salt losing nephritis (Thorn).

(7) Overdose of testosterone.

Dr. McQuarrie dealt at some length with the cases of familial periodic paralysis he had seen. One Minnesota family had several members suffering from this rare disorder, one having lost his life following a huge dinner high in carbohydrate. An attempt was made to see if a ratio could be established between the carbohydrate and potassium ingested to prevent paralysis following carbohydrate ingestion. The fact that carbohydrate excess produced bouts of paralysis was adequately demonstrated as was the fact that potassium salts alleviated and prevented the attacks. Protein had little bearing on the situation except for the fact that the antiketogenic portion of protein metabolism could help in prevention of the episodes of paralysis and so acted much like carbohydrate in the diet.

Cushing's syndrome was then discussed and two cases shown in which the potassium content of the plasma was very low. The removal of one adrenal gave some relief to the symptoms. In studying the electrolyte pattern in this case the serum chlorides were low and the bicarbonate over 100 volumes per cent. This would correspond to the stable states discussed by Darrow.

Infantile diarrhea was then dealt with and reference made to the work of Darrow in demonstrating the loss of potassium that accompanies the diarrhea state and the necessity of replacing the potassium loss as well as the sodium loss.

Similarly, in the treatment of diabetic coma with glucose and insulin, a generalized muscular weakness or paralysis has been reported by several authors. This state is associated with low serum potassium and responds to the use of potassium salts by vein.

A type of low potassium state has been reported by Darrow in a chronic diarrhea in childhood. This child developed an alkalosis rather than an acidosis as a result of his diarrhea. The alkalosis was found to be due to excessive loss of chloride in the stool. This could not be accounted for in any way although heterotopic gastric mucosa was searched for in the intestinal tract. This case showed a lowered potassium in the plasma.

Dr. McQuarrie also mentioned the low potassium state associated with so-called "salt losing nephritis," a condition in which large amounts of fixed base are lost via the urine and likely due to a failure in the ammonia producing mechanism in the tubules.

Mention was also made of the lowered potassium when excess amount of testosterone are administered.

S. Israels.

Abstract

Observations on the Metabolism of Potassium From a Study of the Renal Clearance

H. Ellis and C. Wilson, Archives of Disease of Childhood. Vol. 23; 115:176.

The object of the investigations recorded in this paper was to obtain further information about the metabolism of potassium with particular reference to its rate of excretion in relation to the

plasma level and its retention, if any, by the tissues.

When potassium salts were given by mouth, it was found that the serum level fell, while the renal clearance increased. The low serum level is explained by the ready absorption of potassium by the muscle and especially liver cells; the degree of saturation of the liver and/or tissue cells appeared to be the controlling factor in the excretion of potassium together with some hormone or secretion to promote elimination. It would appear that the excretion of potassium is not determined primarily by the plasma level and that hence it cannot be considered a true threshold substance.

Evidence is also presented that potassium phosphate is more readily taken up by the tissues than potassium chloride. This would suggest that the phosphate rather than the chloride is the more effective salt for intravenous transfusion.

Associated with the retention of potassium, there is an increased output of both sodium and chloride ions. The output of sodium is in excess of that amount which is replaced by potassium. It would appear that this excess of sodium, or at least most of it, cannot have come from within the cells, rather being the result of diminished renal tubular reabsorption.

Ten references, 5 graphs, 5 tables. H. Krivel.

ANAESTHESIOLOGY

Edited by R. G. Whitehead, M.D.

Report of Meeting

The first of the monthly meetings of the Winnipeg Anaesthetists Society for the 1948-49 season was held in the Medical Arts Club Rooms on Tuesday, October 5.

Dr. Lawrence Coke, guest speaker of the evening, presented an excellent paper on "Blood Pressure." In his paper Dr. Coke traced the history of Blood Pressure investigation and discussed the factors governing blood pressure from a physical and chemical standpoint. The cause and effect of both high and low blood pressure and the part played by the carotid and aortic perceptors and the hypothalamus was discussed. A few case histories were presented. An interesting discussion took place following this presentation.

Dr. Fred Walton gave a brief resume of the Anaesthetists' section of Canadian Medical Association Meeting in Toronto.

A short business session terminated the meeting.

R. G. Whitehead, M.D.

Abstract

A Clinical Study of the Effect of Intercostal Nerve Block with Nupercaine in Oil Following Upper Abdominal Surgery.* Robert S. McCleery, M.D., F.R.C.S.; Robert Zollinger, M.D., F.R.C.S., and Norris E. Lenahan, M.D., Columbus, Ohio. (S.G.O., June, 1948, Vol. 86, No. 6).

The authors report on a study of 50 cases in which intercostal nerve block was done in order to evaluate its efficacy in reducing post-operative discomfort and pulmonary complications following upper abdominal surgery. A mixture of 1:1000 nupercaine in peanut oil was used in all cases to give a more prolonged analgesia as compared with local anaesthetics in a water base, and to avoid the possibility of the development of intercostal neuritis from using preparations in oil or benzyl alcohol.

Fifty cases of various upper abdominal procedures were picked at random for blocks, and 30 additional cases were reserved for controls.

In the first 40 cases patients were blocked after the method of Bartlett, in the midaxillary line. The last 10 blocks were performed in the lateral decubitis with the side operated on up, and the injection made posteriorly, 4 fingers from the spinous processes, with the scapula moved forward. This was done in order to block the lateral cutaneous branch of the intercostal nerve which might be missed in the midaxillary block.

Early in the series 1.5 cubic centimeters of 1:1000 nupercaine in peanut oil was used in each of the sixth through the 11th interspaces. This was soon increased to 3 cubic centimeters with no untoward effects and a more effective block. The injection was done at the end of the operation and while the patient was still anaesthetized thus saving the patient discomfort and removing a source of error that might be introduced if the patient received any psychic benefit from the knowledge of the injection. Two cases developed pneumothorax by improper placement of the needles, but both yielded to a single aspiration of air.

The follow-up routine was done by repeated estimations of vital capacity with a McKesson-Scott spirometer on both blocked cases and the controls and the results compared with pre-operative vital capacity estimations. Post-operative narcotic requirements were compared in both series. Pulmonary complications were checked by chest X-ray films when there was an unexplained temperature elevation, questionable physical signs, respirations greater than 28 per minute, cough, pain in chest or cyanosis.

*From the Department of Surgery, The Ohio State University and the Surgical Service, University Hospital.

The results of the investigation, illustrated graphically and by tables, shows that the injected series has an average and a median of 53 per cent of pre-operative vital capacity at the end of 24 hours, compared with 36 or 37 per cent in the controls. The control group did not reach the first day percentage of the blocked group, i.e., 53 per cent of pre-operative vital capacity until the third post-operative day. At the end of 24 hours post-operatively 54 per cent of the block series had more than 50 per cent of pre-operative vital capacity as against only 6 per cent of the controls. The narcotic requirements in the control group were approximately twice that of the blocked group. From this fact the authors deduce that the blocks were effective in reducing post-operative discomfort and yet only rarely did they observe complete skin anaesthesia but most commonly found hypesthesia to protopathic stimuli during the first 48 hours post-operatively. An interesting clinical observation was obtained when patients volunteered the information on the 3rd or 4th day that they were more "conscious" of their incisions than they previously had been.

The incidence of pulmonary complications was 13 per cent in the control group as compared with 6 per cent in the experimental group, this notwithstanding the fact that 37 per cent of the control group received routine penicillin and only 20 per cent of the block series.

In summary (1) the injection of the sixth through the eleventh intercostal nerves with 1:1000 nupercaine in peanut oil was performed in 50 unselected patients immediately following upper abdominal surgery.

(2) The results, when compared with a control series of 30 otherwise comparable cases show: (a) marked reduction in narcotic requirements, which has been shown to be statistically significant; (b) a statistically significant improvement of the expected post-operative drop in vital capacity; (c) reduction in pulmonary complications from 13 per cent to 6 per cent, which we feel to be clinically significant.

(3) Evidence is presented that the drug used had beneficial effects for 48 hours or longer and no undesirable early or late sequelae.

R. G. W.

CANCER

Edited by D. W. Penner, M.D.

Abstract

Bourne, W. A.: Cancer of the Stomach in Addison's Anemia. B.M.J., p. 92, Jan. 17, 1948.

This paper substantiates the previously observed contention that gastric carcinoma and benign gastric lesions occur more frequently in patients with pernicious anemia than in normal individuals of the same age group. The author has followed 15 cases of pernicious anemia by radiograph, gastroscopy and occasional sedimentation rates over a period of two years in the hope of detecting a carcinoma of the stomach in an early stage. Three gastric carcinomas were discovered during this period.

The first of these, a retired jockey, 65 years of age, was first diagnosed as pernicious anemia in 1937 and had been satisfactorily treated. A routine X-ray of the stomach on September 18, 1945, revealed some rigidity in the pre-pyloric region, suggestive of an early scirrhous carcinoma. Gastroscopy on October 31, 1945, revealed the lower third of the stomach fixed and pale with no peristalsis. Laparotomy on February 27, 1946, showed no evidence of neoplasm though the stomach was not opened. In March, 1947, the patient gave a four weeks' history of constant gastric disturbances. X-ray showed a huge filling defect in the pyloric portion of the stomach. Laparotomy on April 9, 1947, revealed an inoperable gastric carcinoma.

The second case was a female, 75 years of age, who had pernicious anemia for 12 years. She was admitted to hospital in May, 1947, with a three months' history of vomiting 3 to 4 times daily. Frequent nausea and retching and a non-localized gnawing feeling in the abdomen. She had recently lost some weight and tended to constipation. X-ray on May 15, 1947, showed stomach to be rather small, normal tone, peristalsis somewhat diminished; and a normal mucosal pattern. Pyloric antrum was narrowed but peristaltic waves passed through this portion which was distensible. No evidence of gastric or duodenal ulcer appeared. Gastroscopy at this time revealed small reddish nodular protruberances at the angulus; antral peristalsis and pyloric closure were active. Impression formed was neoplasm. A partial resection was done on May 27, 1947, the pathological report stated that this stomach showed the earliest possible malignant change, confined to epithelium.

The third case was a male, 70 years of age, who had suffered from pernicous anemia since 1934. No symptoms were present on the 30th of May, 1947, when a routine stomach X-ray showed a somewhat narrowed pyloric antrum. Peristaltic waves, however, passed through the region and

this factor pointed against the diagnosis of carcinoma. Gastroscopy at this time showed an irregular nodular angulus and the pylorus closing irregular. Laparotomy on October 8, 1947, revealed an inoperable carcinoma of the stomach.

A benign leiomyoma was discovered at laparotomy in another patient who had suffered from pernicious anemia for four years. Another case of the author's was a 77-year-old male with a one-year history of pernicious anemia who gave a suspicious history but not considered sufficiently diagnostic to permit laparotomy. Gastroscopy in this case revealed a reddish nodule on the greater curvature.

The author attributes the success of early diagnosis to the X-ray which showed a narrowing in the antral region. The gastroscope was found useful for diagnosis and confirmation. The author suggests altering our pathological, radiological and gastroscopic criteria to enable gastrectomies to be done with some hope of cure.

The author refers to the work of Jacobson and Palmer (1943, Gastroenterology 1, 1133) on the effect of anemia on gastric emptying. These authors determined the gastric emptying time fluoroscopically in a group of untreated (in relapse), and treated patients with pernicious anemia. A group of 10 normal medical students and a number of patients with anemias of undetermined or obscure etiology were studied for comparison.

Significant prolongation of gastric emptying occurred with one exception in those patients whose peripheral erythrocyte count was below 1.5 million, regardless of the etiology of the anemia. These patients had mild to severe abdominal complaints which cleared up along with the prolonged gastric emptying after institution of adequate therapy. Achlorhydria per se does not significantly effect the rate of gastric emptying.

The work of Rigler, L. G.; Kaplan, H.S., and Fink, D. L. (1945, J.A.M.A., 128; 426) is also referred to by the author. Rigler et al who made a roentgen study of 211 pernicious anemia patients found carcinoma of the stomach in 8% and benign polyps in 7.1%. The first two authors in a previous review of 43,021 consecutive autopsies found 293 cases of pernicious anemia in persons over the age of 45 years. Of these 36 were found to have a carcinoma of the stomach (12.3%). This is about 3 to 4 times as common as in the same age group in "normal" people. Most investigators feel that there is a common precursor of the two diseases, rather than that the one is due to the other. Many studies point to an hereditary or familial deficiency which predisposes to both diseases.

The author makes a final reference to an article by Magnus, H. A. (1938, Lancet, 1,420), in which 7 cases of pernicious anemia were studied at autopsy for gastric changes. This article revealed that in all cases a characteristic lesion is present, localized to the region of the body mucosa and not effecting the pyloro-duodenal region. This lesion affects all coats of the stomach wall, and from its histologic appearance is almost certainly not the end result of an inflammatory process. The possible bearing of these findings on the problem of the site of formation of the intrinsic factors in pernicious anemia is discussed.

J. C. Wilt, M.D.

GYNECOLOGY

Edited by R. Lyons, B.A., M.R.C.S., L.R.C.P., M.R.C.O.G.

Case Report

Dr. Ralph T. Robinson

Mrs. W., a robust white female, aged 30 years, was first seen in October, 1946, complaining of severe headache during the preceding year. At first headaches were associated with menstruation but recently have become continuous and have occurred at least each week since June, 1946. Headache is general, but if severe, occipital. Occasional vomiting associated with it and often associated with nausea. Menstruation started at the age of 15 and in the first year bleeding was so profuse that she could not go to school. In the past year the flow has reduced from seven days to four days and the flow is scanty. A diagnosis of Migraine associated with oligomenorrhea was made and patient was started on tablets ovocylin, .2 milligrams B.I.D. for a week and then one daily for a week. Within one month, headaches were entirely relieved and the menstrual flow increased to normal.

Patient was next seen in June, 1948, at which time she gave a history of sterility for fourteen months. Energy was markedly reduced and patient fatigued easily. Weight has been slowly increasing, haemoglobin and blood pressure were normal. B.M.R., minus 21%. Patient was started on desiccated thyroid and general picture definitely improved. L.N.M.P. occurred on July 5th. As periods had been every 28 days, the next expected menstruation was August 2nd, but period did not commence until August 15th and patient thinks that she had a normal menstruation which was subsequently followed by daily spotting.

On the evening of September 11th, about 8.30 p.m., she suddenly developed acute abdominal pain which increased in severity so that she

doubled up and almost fainted. She was seen about an hour after the pain had started and at this time the acute pain had subsided. Patient only complained of soreness in the right side of the abdomen. She said that when the pain had been acute it was below the right costal margin, in the right loin and radiated to the urethra. Examination of the abdomen revealed tenderness at the level of the umbilicus and in the costa-vertebral angle. There was also moderate tenderness in the lower abdomen mid-line. Temperature was normal and pulse was normal.

A tentative diagnosis of right renal colic was made and patient was given mild sedation and heat was applied and the distress abated. She had no real pain throughout the night or on the following morning. By mid-afternoon September 12th, pain had increased in severity so that the patient, when seen, was shivering and pale. In addition to the pain in abdomen, patient stated that she had now developed pain radiating to the right shoulder and right scapula and this pain increased on deep respiration. Keeping in mind the early symptoms of this patient, relative to the urinary tract, she was admitted to Hospital and after admission she voided ten ounces of urine without difficulty. Intravenous pyelogram was done and this revealed a functioning right kidney, the left kidney was normal. Chest X-Ray, A.P. and Lateral, were then done and there was no pathology in the chest. Leucocyte count was 23,000 and urinalysis was negative for pus or blood. Temperature was normal, pulse about 80. Pelvic examination was then carried out after catheterization of the bladder in which 27 ounces of urine was found. Pelvic examination revealed a cervix which was undoubtedly that of a pregnant uterus, it was soft and patulous and there was blood in the vaginal tract.

A diagnosis of ruptured ectopic pregnancy was arrived at. Patient was taken to the operating room where the abdomen was opened through a lower right paramedian incision and as soon as the peritoneum was exposed it was found to be bluish. As soon as the peritoneum was opened a large amount of blood was aspirated and examination of the pelvic viscera revealed a ruptured left fallopian tube, and the contents of the tube were extruded into the pelvis. The tube was removed and examination of the remaining pelvic viscera revealed normal ovaries and a normal right tube. The abdomen was closed and patient returned to the ward in good condition and made an uneventful recovery.

TUBERCULOSIS

Cultivation of Tubercle Bacilli; Analysis of One Thousand Consecutive Cultures

Joseph M. Scott, M.T. (ASCP), R.T. (Canada)

Senior Medical Technologist
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Robert Koch[1] was the first person to see the tubercle bacillus microscopically, and also the first to isolate it in pure culture. The methodical and logical experiments which resulted, in 1881, in the production of the first culture of tubercle bacilli ever grown, are brilliantly recorded in his classical paper "The Aetiology of Tuberculosis." Blood serum was the only suitable medium available, glycerol as a good nutrient for tubercle bacilli had not yet been discovered, nor had paraffin for impregnating the cotton plugs of culture tubes to prevent drying. Dr. Allen K. Krause speaks of his infinite patience, which amounted almost to genius, in continuing to observe his cultures long after the two or three days then considered sufficient for the growth of all bacteria known at that time.

Edward Livingston Trudeau[2], founder of the first sanatorium for tuberculosis, the famous Trudeau Sanatorium at Saranac Lake in New York State, was the first person to grow tubercle bacilli in America. Inspired by the famous paper just mentioned, he bought a microscope and learned how to stain the tubercle bacillus. Later he devised a simple, but ingenious, home-made thermostat, heated by a kerosene lamp, and succeeded in isolating the tubercle bacillus by culture.

There has been a considerable increase in the use of cultures in recent years for identification of the tubercle bacillus, not only in tuberculosis laboratories but in other types as well. This is perhaps due in part to recognition of the fact that the direct smear, and even concentration methods, fail to detect tubercle bacilli in a great many tuberculous specimens, and fall short in providing sufficient evidence of negativity in tuberculosis. Furthermore, methods for destroying contaminating bacteria have been improved, and many varieties of satisfactory culture media are available. Pinner[3], in speaking of the significance of culturing sputum and gastric contents, has said recently, "If frequent and technically expert studies are made both positive and negative results have a diagnostic importance equalled by few laboratory procedures in any disease."

Requirements for a Good Culture of Tubercle Bacillus

There are two major requirements for the satis-

factory cultivation of the tubercle bacillus: first, a good method for destroying contaminators; and second, a suitable medium for the growth of the organism.

Numerous bacteria grow in the same environment as the tubercle bacillus in most of the materials to be examined, such as, sputum, urine or gastric contents. Destruction of contaminators depends upon the fact that the tubercle bacillus is more resistant to the destructive action of acids, alkalies, or other reagents than are most other organisms with which it is associated. It must be remembered, however, that a certain number of the weaker tubercle bacilli may be killed by any reagent, hence accurate timing of this phase of treatment is usually necessary.

Most of our recent experience has been with two reagents, 5 per cent oxalic acid and 5 per cent sodium hydroxide. Sodium hydroxide is a good reagent because it liquifies mucoid material, and it allows better centrifugation than do the acid treatments. Fairly close timing at about 40 minutes is necessary with both reagents for best results. This necessity for accurate timing is overcome to a considerable extent by use of a reagent recently advocated by Corper and Stoner[4]. They found that 10 per cent trisodium phosphate destroyed most contaminators in 24 hours at 37°C., but did not appreciably affect the viability of tubercle bacilli in one week at room temperature. We have not tried it ourselves, but I know of one laboratory in Ontario in which it has been found to give good results.

The contaminated state of most specimens to be cultured for tubercle bacilli can be minimized by certain precautions, especially the use of sterilized containers for collection of the specimens and also for all subsequent procedures. We had not realized that this step could make so much difference until recently, while carrying out a special series of sputum cultures, when we started collecting morning specimens in sterile bottles rather than in the usual paper sputum cups. The patient had also been instucted to clean his teeth and rinse his mouth before raising the sputum, thus eliminating much mouth bacteria. We found that the number of contaminated cultures was almost eliminated by this procedure. The same would be true of other materials in a varying degree. Gastric contents, for example, are heavily contaminated, and even with the most careful technique, it is frequently impossible to avoid getting some contaminated cultures. Urine can be obtained fairly free of contamination if collected in a sterile container, but catheterization in the female is advisable. Materials brought to the laboratory on swabs are always difficult to culture for tubercle bacilli, especially if contaminated. We had occasion recently to culture pus taken on a swab from the cervix, and obtained a positive culture by washing the pus off into a few cubic centimetres of sterile saline, then treating this fluid with 5 per cent oxalic acid in the same manner as for any other suspected tuberculous material.

Very many different culture media have been devised since Dorset's whole egg medium appeared in 1902, including Petroff's gentian violet egg (1915), Petragnani's (1926), Corper-Uyei's crystal violet potato (1929), Herrold's (1931), Lowenstein's (1933), Sasano and Medlar's (1943), to mention only a few of them. Their very number suggests that each, though good to a degree, lacked certain qualities that would make it universally acceptable as the ideal medium for the growth of tubercle bacilli.

Media containing egg or potato appear to be the most effective for the primary isolation of tubercle bacilli. Corper and Cohn[5], whose experience in growing tubercle bacilli is very extensive, have criticized many of the media just mentioned as being too complicated and difficult to prepare, and have recommended instead a simple glycerol egg-yolk medium, first introduced by them in 1933, as being more efficient than any multiple mixture medium they had analyzed for the culture of small numbers of tubercle bacilli. We are trying this medium at the present time, but it is too early to report any results.

Material for Culture Study

The material for this study consists of 1,000 consecutive cultures made for the tubercle bacillus at Manitoba Sanatorium in a 26-month period between November, 1945, and January, 1948. Most tests were of a routine nature and the specimens came from patients on treatment for tuberculosis, but quite a number were made for diagnostic purposes, and a few for experimental reasons. The type of material examined varied, but the great majority of specimens were gastric contents.

The preliminary treatment used for destroying contaminators in gastric material was that recommended by Sasano and Medlar[6]: 5 per cent sodium hydroxide solution, but applied for 40 minutes instead of 20, followed by centrifugation and neutralization with a special buffer solution. The method of Corper and Uyei[7], slightly modified, was used for sputum, urine, and other contaminated materials, that is, treatment with 5 per cent oxalic acid solution for 40 minutes, followed by double washing and centrifugation with sterile physiological saline solution to remove the acid. An aspirated fluid, such as pleural fluid, is usually uncontaminated, and no treatment may be required but centrifugation.

Three culture media were used in our study: (1) Lowenstein-Jensen, henceforth simply called Lowenstein, produced by Connaught Medical Research Laboratories of Toronto; (2)) Petragnani made by Difco Laboratories, Incorporated of Detroit; and (3) Petragnani made in our own laboratory according to the directions given by Macklin and Wales[5]. In nearly every test two tubes were inoculated, usually one of a commercial medium, the other one of our own Petragnani.

Discussion of Results

The 1,000 cultures in the study were done on 501 patients, the great majority having one to four tests each, though a few had more. Mention might be made of one patient having eleven cultures, of which six were positive, bacilli being grown from gastric contents, pus from cervix, and urine. Another patient, a former Hong Kong prisoner, had five positive cultures out of eight, bacilli being found in sputum, gastric contents, and pleural fluid.

Two hundred and ninety-nine cultures of tubercle bacilli were obtained, or 29.9 per cent. Van Vranken[9] reported 23.5 per cent positives in her series of 1,000 cultures, mostly of sputa, using egg-yolk medium. Gastric contents, which are examined because of swallowed sputum, led the list with 755 specimens and 30.1 per cent positives, compared to 28.8 per cent for 73 sputum specimens. The positive findings from pleural fluid were 34.9 per cent of 86 specimens, urine 23.3 per cent of 43 specimens, pus 22.7 per cent of 22 specimens, and cerebrospinal fluid 16.7 per cent of 12 specimens. The difficulty of finding tubercle bacilli in cerebrospinal fluid is well known, but the culture should not be omitted, because, if positive, it gives valuable confirmatory evidence of tuberculous meningitis. We do not treat the fluid, but simply add about ten drops to each of two culture tubes, then incubate them in a horizontal position.

Two luxurious growths of Bacillus Calmette-Guerin, an avirulent bovine tubercle bacillus, were obtained on Petragnani medium from B.C.G. vaccine, an interesting finding because this medium contains glycerol which is not usually favorable to the growth of the bovine bacillus.

Observation of the number of colonies growing in each positive culture tube was made, and it was surprising to find that in 123 tubes out of 444, or 28 per cent, only a single colony of tubercle bacilli had grown. In about 40 per cent of the tubes the colonies numbered from two to about fifteen, while in the remainder there were many colonies. This finding emphasizes the necessity for careful scrutiny of the cultures, otherwise very small colonies can be easily overlooked.

Further analysis showed that when two tubes were inoculated growth occurred in only one of the pair in 145 of 295 tubes analyzed. This finding suggests that, if only a single tube were used for a test, many positive results would be lost, while on the other hand the use of more than two tubes would likely result in a greater number of positive results.

Only four cultures were completely lost by contamination, though in 26 cases one tube of a pair was lost for the same reason. These losses were lower than anticipated, but there were many cases in which some contamination occurred, but not enough to entirely spoil the culture. A frequent contaminator in gastric contents cultures was an unidentified, slowly spreading diphtheroid. Molds were troublesome at times and tended to appear in batches; we believe their appearance was often due to breaks in technique or to poor sterilization of culture tubes. I would like to emphasize again that careful attention to detail at every step in the collection and handling of materials for culture is one of the best means of avoiding losses from contamination.

We were interested in determining the efficiency of our own medium as compared to the two commercial types we had been buying, particularly since the market price was 28 to 36 cents a tube for the prepared medium. We have estimated that our own medium can be prepared for about eight cents a tube, which would permit a considerable saving if the medium is as good culturally as that prepared in a factory. We did find that our medium compared favorably with the Difco Petragnani and with the Lowenstein. In a comparative series of 339 cultures for tubercle bacilli growth occurred on our Petragnani in 30 cases in which it failed to appear on Difco Petragnani, while the reverse was true in 18 cases. In another similar series of 269 cultures growth occurred on our Petragnani in 27 cases when the Lowenstein was negative, but the reverse was true in 21 cases. Although we prefer Petragnani medium, these findings show that better results can be obtained by the use of more than one medium.

Colonies of tubercle bacilli show up more prominently on Petragnani medium than on Lowenstein. This bears out an early observation of Corper and Cohn[5] that growth on a medium containing potato (as Petragnani) is of the elevated, heavy, wrinkled type, while on a predominantly egg medium (as Lowenstein)) the growth is flat and spreading.

Growth occurred about as early on one type of Petragnani as on the other, but in this series it was definitely slower on Lowenstein than on either type of Petragnani. The time of first appearance of growth on Difco Petragnani ranged from 15 to 55 days, with an average of 32.4; on our Petragnani, 12 to 66 days, averaging 32.9; while on Lowenstein

took 15 to 72 days, averaging 38.1. As cultures were usually observed at weekly intervals, the times given are slightly longer than the actual time in many cases.

Doctors are interested in knowing how soon they may expect a report on cultures. In our series only four cultures had been found positive by the end of two weeks, but at the end of the third week 72 per cent of all the positive results were known, the fourth week 37 per cent, the fifth week 93 per cent, the sixth week 80 per cent, the seventh week 90 per cent, and by the ninth week 98 per cent. We usually discard our cultures after two months of incubation, if still negative microscopically.

The relative efficiency of cultures and direct smear examinations was determined on 968 specimens. Of these 310 proved to be positive, either by culture, by direct smear, or by both methods; direct smears were positive in 26 per cent, cultures in 94 per cent. The high percentage of positive smears was due, in part, to the inclusion of a number of known positive specimens for experimental purposes.

The failure to grow tubercle bacilli from every specimen found positive by direct smear is one of the puzzling problems in a sanatorium laboratory, and one can only conjecture as to the causes of failure. In our series this discrepancy occurred 19 times, that is, in about 2 per cent of the cultures. Van Vranken[9] had the same experience in 7.7 per cent of her series of 1,000 cultures.

On the other hand we have repeatedly had the experience of getting positive cultural confirmation of specimens in which direct smears showed only one or two bacilli, so few, in fact, that one hesitated to make a positive report. Cultures are particularly valuable in confirming doubtful smear findings in gastric contents, since tubercle bacilli are never very plentiful in this material. Then, too, many of the tests had been done as aids in diagnosis, and frequently tubercle bacilli had never been found before. Out of a series of 197 patients having positive cultures, 35, or 18 per cent, had never had tubercle bacilli found before; in 32 the bacilli were first found in gastric contents, and in one each in pleural fluid, urine and pus. In another series of patients with minimal pulmonary tuberculosis[10] it was found that of 81 having tubercle bacilli 34, or 42 per cent, were first found positive by means of culture.

Fifteen strains of acid-fast bacilli, considered to be saprophytic, were encountered in the 1,000 cultures, eleven being found in gastric contents, two in pleural fluid, and one each in urine and sputum. The colonies of most strains were orange in color, soft and creamy, but two at last were whitish-yellow, and were at first considered to be tubercle bacilli. Most of the strains were tested in guinea pigs, and in many cases produced no lesions at all; in a few, however, localized abscesses occurred at the site of injection, while in several others internal lesions were found that did not resemble those produced by inoculation tuberculosis. One strain was recovered by culture from several organs of a guinea pig into which the original strain had been injected. It is important that all doubtful strains of acid-fast bacilli be tested for pathogenicity in guinea pigs, and with a little experience very few of these saprophytes are likely to cause serious difficulty in differentiation.

In conclusion, I would like to say that technicians, even in the smallest hospitals, should have success in growing tubercle bacilli, provided that there is an incubator in the laboratory, a few simple reagents and pieces of apparatus, and also that culture medium can be made or obtained easily. Try it, and see for yourself.

I wish to thank Dr. A. L. Paine, Medical Superintendent, Manitoba Sanatorium, Ninette, for permission to use the material presented in this paper; Mrs. A. Samolesky, Miss N. McIvor, Mr. C. Ground, and Mr. J. T. King for most of the technical work, and Miss M. Kennedy for aid in collecting the data and in preparing the manuscript.

References

1. Koch, Robert: The aetiology of tuberculosis, translated by Berna Pinner and Max Pinner, with an introduction by Allan K. Krause, Am. Rev. Tuberc. 25: 285-323 (March) 1932.
2. Trudeau, Edward Livingston: An Autobiography, Doubleday, Doran & Company, 1928, pp. 173-191.
3. Pinner, Max: The bacteriological diagnosis of pulmonary tuberculosis, Veterans Admin. Tech. Bull., Oct. 10, 1946; abs. in Tuberc. Abs., March, 1948, issued by Nat. Tuberc. Assoc.
4. Corper, H. J., and Stoner, R. E.: An improved precedure for the diagnostic culture of mammalian tubercle bacilli, J. Lab. & Clin. Med. 31: 1364-1371 (Dec.) 1946.
5. Corper, H. J., and Cohn, Maurice L.: The nutrient quality of eggs for growing tubercle bacilli, Am. J. Hyg. 18: 1-25 (July) 1933.
6. Sasano, K. T., and Medlar, E. M.: Egg-yolk-potato medium; its efficiency for demonstrating small numbers of tubercle bacilli, Am. Rev. Tuberc. 48: 297-303 (Nov.) 1943.
7. Corper, H. J., and Uyei Nao: Oxalic acid as a reagent for isolating tubercle bacilli and a study of the growth of acid-fast nonpathogens on different mediums with their reactions to chemical reagents, J. Lab. & Clin. Med. 15: 348-369 (Jan.) 1930.
8. Macklin, I., and Wales, R.: Gastric lavage and culture for the detection of tubercle bacilli, Canad. J. M. Technol. 3: 57-60 (Mar.) 1941.
9. Van Vranken, Marjorie: Diagnostic culture of tubercle bacilli; a simplified procedure in public health work, Am. Rev. Tuberc. 55: 374-378 (Apr.) 1947.
10. Scott, Joseph M.: Minimal pulmonary tuberculosis; laboratory findings in 118 cases, Canad. J. M. Technol. 9: 33-41 (June) 1947.

OBSTETRICS

A New Instrument and a New Method of Doing Episiotomies

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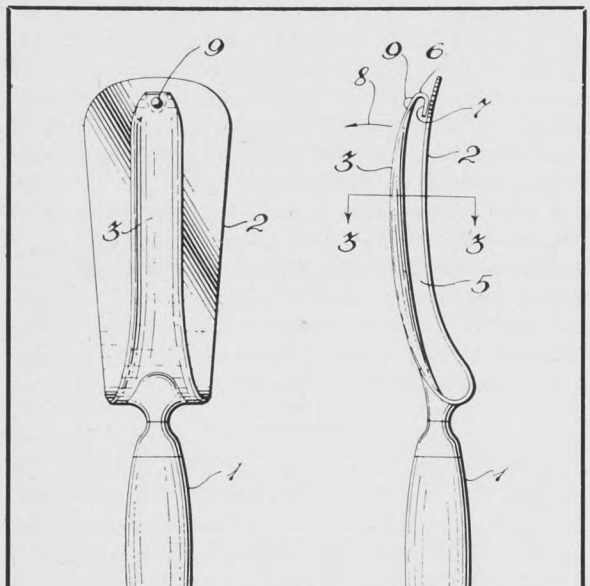
This device relates to surgical instruments, the object being to provide an instrument of the character herewithin described primarily for use in episiotomies, whereby the technique of such operations may be improved by permitting the insertion of sutures prior to making the incision.

Further advantages reside in the fact that, with the use of the herein described instrument, an episiotomy may be performed in less time than by



conventional procedures; the patient is caused less pain; exact apposition of the incised tissues is assured; surrounding structures are protected while the incision is being made; the infant's head is protected from the scalpel while the incision is being made; the operation being performed earlier, the period of labor tends to be shortened; stretching and bruising of tissues is avoided by the earlier performance of the operation; post delivery anaesthetic is rendered unnecessary since the sutures are already inserted.

With the foregoing objects in view, and such other objects and advantages as will become apparent to those skilled in the art to which this invention relates as this specification proceeds, the instrument consists essentially in the arrangement and construction of parts all as hereinafter more particularly described, reference being had to the accompanying drawings, in which:

Figure 1 is a front view of the surgical instrument.

Figure 2 is a view of the instrument taken at right angles to Figure 1.

Figure 4 is an anatomical representation illustrating the instrument in situ for a medio-lateral episiotomy with the sutures inserted and in readiness for the making of the incision, a portion of this representation being shown in fragmentary form to illustrate the end of the instrument remote from the handle in full line.

Figure 5 is a representation similar to Figure 4 but a little later in the stage of labor, and wherein the incision has been made and the instrument withdrawn together with the sutures prior to release of same from the instrument, after delivery is completed and the third stage of labor over.

In the drawings like characters of reference indicate corresponding parts in the different figures.

The standard procedure in the performance of episiotomies consists in making the incision when the tissues are fully stretched and almost at the point of rupture. The incision is made with scissors and the necessary repair is done and sutures inserted after delivery. This necessitates the administration of post-delivery anaesthetic which increases the risk of hemorrhage.

By contrast, the improved technique is undertaken with the essential aid of the instrument about to be described. Proceeding therefore first to describe the instrument **per se** the same consists of the following parts in the stated relationship:

To a manipulating handle 1 is secured in coterminous and counter-curving relationship, a shielding element 2, and an elongated, flexible, scalpel and suture guide 3, the latter being transversely concave substantially the length thereof upon what I consider the exterior surface 4.

The shielding element 2 is of substantially planer transversity, but is longitudinally curved as best illustrated in the accompanying figure 2 as is also the guide 3, so that the curvature of the parts 2 and 3 may be considered as approximately parallel.

The parts 2 and 3 are spaced to provide the elongated opening 5, and integral with the end of the guide 3 remote from handle 1 is a hook 6, the inner end 7 of which is normally in contact with the adjacent surface of the shielding element 2. The guide 3 is, however, longitudinally resilient, and hence may be flexed to a limited extent in the direction of the arrow 8, whereby hook 6 may be

moved away from element 2 for the purpose of releasing suture threads as will be hereinafter described.

Having now described the structure of the surgical instrument, its manner of use will be explained.

At the appropriate time during the period of labor, the instrument is pushed into the passage between the tissues and the head of the infant, in an outward and rearward direction, as clearly illustrated in the accompanying Figure 4, and there held firmly in place. Sutures 10 are now inserted through the skin and the tissues below adjacent one edge of the suture guide 3, the conventional curved needle carrying the suture through the elongated opening 5 between the guide 3 and the shielding 2, and emerging adjacent the opposite edge of the guide.

The sutures and the instrument may be maintained as described up to this point and as illustrated in the accompanying Figure 4 until it is desired to make the incision indicated in Figure 5, and when the incision has been made the instrument is withdrawn, at which time the portions of the several sutures extending through the opening 5 accumulate to be intercepted by the hook 6.

Thus the instrument pulls the sutures as indicated in the Figure 5 to the extent necessary to provide enough slack suture to accommodate the maximum distension of the incision during delivery. When sufficient suture has been drawn to provide the necessary slack, the instrument is rotated longitudinally outward and rearward and the instrument together with the forceps on the retaining loose sutures are tied in a roll with a bandage and placed under the lower part of the buttocks on the side of the body on which the episiotomy has been performed and remains there until the third stage of labor has been completed. The sutures are then released from hook 6 on instrument by flexure of guide 3 in direction of arrow 8 so that the sutures may be allowed passage around hook 6. It is important to leave the forceps attached to suture ends tying one suture before removing forceps from the next. The incision is neatly and cleanly closed and leaves an almost invisible scar. The proper length of suture is about 14 inches.

From a consideration of the foregoing it will be clearly apparent that the member 3 functions, by virtue of its transverse curvature, not only as a guide for the suturing needle, but as a guiding trough for the scalpel, which, together with the shielding element 2 protects the infant's head from injury.

The proper time for the use of the instrument during labor must be left to the judgment of the obstetrician. It will be found, however, that the operation for the lessening of tension on the perineal structures known as episiotomy, can be performed much earlier with the instrument than in

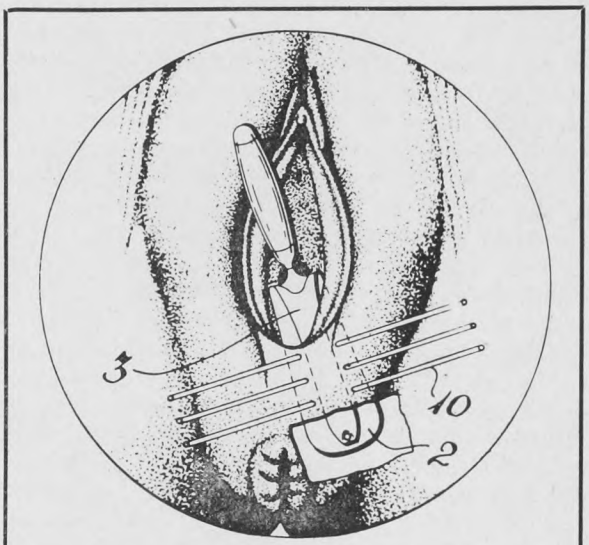


FIG 4

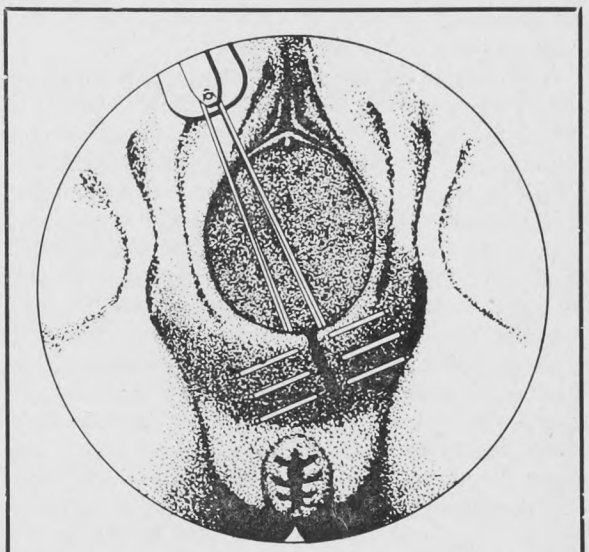


FIG 5

the old way. The tissues of the perineal floor will not be stretched and devitalized as much if the episiotomy is done early, and the healing and ultimate repair is definitely more satisfactory.

For the performance of a lateral episiotomy, the instrument is gently pushed into the passage

between the wall of the passage and the infant's head at the point of selection for the episiotomy. See Figure 4.

The instrument is held firmly in place, and sutures are placed beginning at the edge of the passage, 1, 2, 3, 4, 5, sutures as the operator decides. Suture No. 1 should be placed close to the edge of the passage, and the others spaced as desired, not more than three-eighths of an inch apart, toward the distal end of the instrument, which can be felt readily under the skin and underlying structures. It is important that the first suture should be close to the edge of the vaginal wall, as it makes the apposition of the cut edges perfect when the suture is tied. The sutures should be placed during a contraction of the uterus, or as we say "during a pain," so that the infant's head bears on the protecting plate of the instrument and puts the tissues on the stretch. Use a large curved obstetrical needle, obstetrical 40-day catgut suture—a 28-inch suture should do two sutures, or stitches. See method of inserting sutures in Figure 4. An artery forcep is placed on the ends of the sutures to prevent them being pulled out during manipulations and after movements of the patient. When the sutures are all placed have the assistant hold the sutures taut at right angles to the episiotomy incision, the operator holds the instrument firm in the correct position, makes the incision through the skin and underlying structures down to the suture groove in the instrument.

The handle of the instrument is now elevated and rotated outward, taking the loops of the sutures out of the incision and away from the oncoming head and on the afterbirth. If this were not so, they would be caught on the ears and other parts of the head and afterbirth. The hook on the under surface of the suture guide automatically looks after this. The forceps and the instrument with the sutures attached are then held together and a bandage placed around them to keep them together until the third stage of labor is completed.

The protecting blade of the instrument and the incision groove with hook are slightly separated, when the loops of the sutures will be freed, the artery forceps on the ends of the sutures lifted up, and the edges of the incision will come together accurately as the sutures were put in before the incision was made. If the operator wishes to put in deep sutures he can do so, and then tie the original sutures. Personally I have done many episiotomies without any deep suturing and had perfect results, healing by first intention, with perfect operation scars.

Many times I have made the episiotomy earlier than usual, and had the head born during the first succeeding pain. It saves the mother's strength (every pain saved helps the mother), it certainly helps the oncoming head, and I believe helps to prevent intracranial hemorrhage—the tissues are not stretched to breaking point before the episiotomy is done, and have the proper power of retracting and healing more rapidly and completely.

There are two types of episiotomies (1) mesio-lateral and (2) central. Either of the types may be performed with the instrument described above. The mesio-lateral has been fully described in the above article and has been very satisfactory in the writer's work—in fact so satisfactory that the central type has been abandoned. It is the writer's opinion that an incision in the central perineum is more weakining to the pelvic floor afterwards and does not heal so well, probably due to a more tendinous nature of the tissue where it joins the median raphe of the perineum.

In performing the central type of operation, direct the instrument first backward for the desired distance, put in three or more sutures, then direct the instrument around the anus and insert the balance of sutures and proceed as with mesio-lateral type of operation, making the incision down to the groove in the instrument, first making the incision around the anus, avoiding the sphincter muscle, and forward to the vagina. The remainder of the central episiotomy is carried out exactly as the Mesio-lateral with regard to tying sutures.

In patients having a short perineal space between the posterior vaginal wall and the anus, a right lateral and a left lateral episiotomy can be done with good results.

A Summary of the Advantages of This Instrument

(1) The Episiotomy can be done earlier.

(2) The birth is completed sooner.

(3) The stretching of the perineum is less and the pressure on the bladder and the rectum is less.

(4) The use of the scalpel instead of scissors in making the incision promotes more rapid healing.

(5) The infant's head is absolutely protected while making the incision.

(6) No necessity for post delivery anaesthetic for suturing the episiotomy.

(7) The incision heals better and the scar is neater because of perfect apposition of part of the skin and tissue.

(8) Hemorrhage from incision is easily controllable by putting in a suture along edge of instrument, on either side from the outer end of the incision to the edge of the passage. Tie the suture tight enough to control the hemorrhage and remove at end of third stage when other sutures are tied.

(9) Takes fewer assistants, an important factor in Home Obstetrics.

(10) The sutures are placed at a time when the patient is best able to stand suturing, instead of after a long hard labor.

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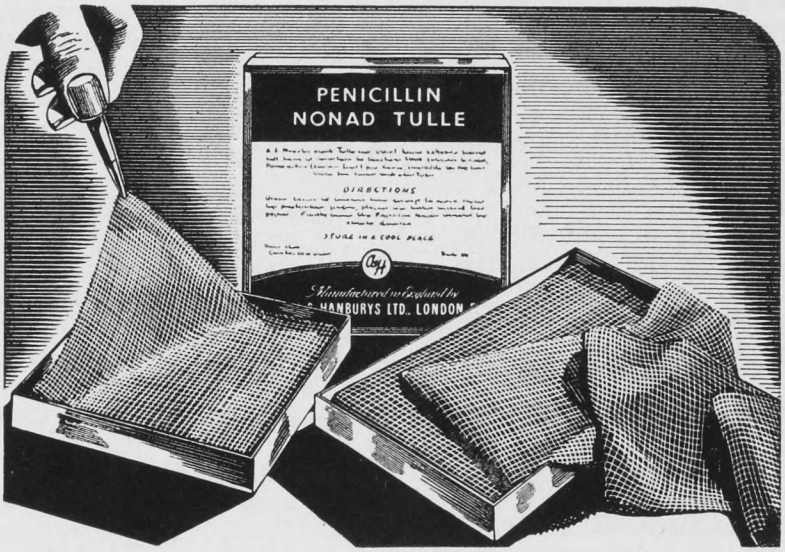

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Notes on the World Medical Association

Anna Wilson

"To what fortuitous concurrence do we not owe every pleasure and convenience of our lives."

The 2nd annual meeting of the World Medical Association was called for Wednesday, September 8th, at the Town Hall, Geneva, Switzerland. As Lady Banting was unable to attend, Dr. T. C. Routley, general secretary of the C.M.A.; and chairman of council for the W.M.A., confirmed my appointment as observer on August 31st. I left Winnipeg on September 4th, Saturday, by T.C.A.

From Winnipeg to Dorval, Quebec is an uneventful journey of 4 hours in a pressurized North Star Craft. Five babies under two on board attested to the excellent travel by sleeping all the way.

Because of storms and fog at sea the T.C.A. plane did not leave until noon the following day. (Sunday). We had comfortable quarters at the Dorval Inn overnight. Sunday was a beautiful day, one felt "the magic in the distance where the sea line meets the sky." We stopped for a brief interlude at Gander on the way then off to London in the new North Star.

When Darwin wrote "Wide waving wings expanded bear the flying chariot through fields of air" he could not have imagined that within 12 hours one could view a beautiful sunset on this continent and a more colorful sunrise on the other.

The pressurized cabin eliminated unpleasant ear noises and discomfort. We landed at Heathrow and proceeded to London Air Terminal. Then by cab to Kensington Air Terminal to arrange with Swissaire to go to Geneva. As it was 8 a.m. and the plane did not leave until 1 p.m. I contacted friends near Canada House who undertook to distribute the 25 pounds of bacon I had brought. I delivered a precious dozen of fresh eggs to Matthew Halton of BBC fame—these eggs were sent by a Winnipeg admirer of his broadcasts.

At noon we left Kensington Air Station for Northolt Airport and flew easily in a small plane for Geneva. Miss Martindale, a British surgeon, was en route to the conference as a British observer on the same plane.

At teatime I was in the rotunda of the comfortable Hotel de la Paix on the quai of Lac Leman drinking tea with Winnipeg friends who are in the Canadian diplomatic service in Geneva. So in spite of delays in Dorval and London one could breakfast in Winnipeg on Saturday and have tea in Geneva on Monday.

Dr. T. C. Routley, chairman of the W.M.A., and Dr. Jack Anderson (Saskatoon), president of the C.M.A., arrived with Dr. Charles Hill, secretary of the B.M.A. and honorary secretary of the W.M.A. I met them all, we were joined by Mrs. Hill and had a delicious dinner at the hotel.

Over the tables from the discussion one could conceive the magnitude of the game these medical people were playing. As the conference proceeded my respect for Dr. Routley increased. Canada is fortunate to have a man with ability and ideals to represent her internationally. Diplomatic yet direct, he is well informed in assembly and most popular with all delegates.

Dr. Charles Hill is the re-incarnation of John Bull. He speaks like Churchill—has an amazing fire and wit and is a great worker. When you hear he is to be Conservative Candidate for Luton and that Churchill actually spoke at his rally you have the measure of the man.

We walked afterward along the quai to glimpse the beauty of the city of Geneva. It reminds one of a perfect set with a play ready to begin—the swans in the lake, the boats with bright sails, the colorful houses; the spire of the cathedral painted in play-like proportions on the opposite shore—the back drop the highest chain of peaks in the Alps and over all bathed in light the highest peak, serene Mont Blanc. It seems too perfect to be real.

Along the quai is the Kurasel—where we won Swiss Francs when we played—and the Brunswick monument to Charles, Duke of Brunswick, who gave his fortune to beautify Geneva. Passing along the Quai des Bergues, one can see Rousseau Island and over the Pont d'Ille stands the remains of an old Tower—recalling the days of Bishopdom. A record in the wall of the tower defies the tooth of time "Julius Caesar passed this way in 58 B.C."

On Tuesday, September 7th, I rose early and in the full tide of successful experiment travelled to Berne by train. Some of the British delegation were jolly companions. The countryside was beautiful—vine yards on slopes, deep valleys with swift, clear rivers, green hill sides, quaint houses with red tiled roofs on the steep inclines and broad sweeping miniature "foothills."

We arrived and hastened through picturesque arcades in the shopping district to hear the "Apostle Clock" strike twelve. We returned to the square, like children, at 1 and 2 to hear the cock crow; and see the hammer strike the huge bell and the apostles come out. We shopped in quaint places, viewed the Cathedral and fed the dancing bears. On returning to Geneva, the sun shining on Mont Blanc gave one an impression of joy.

That evening, Dr. and Mrs. Steinman displayed genuine Swiss hospitality. We met delegates from many countries at their home.

On September 8th the business of the conference began early at the Salle des Grand Conseil

ue de l' Hotel de Ville. We registered at 8.45 he session started at 9.45 with greetings by Dr. lbert Picot—President of the Swiss National ouncil and from the Swiss Federal authorities.

Dr Routley, as chairman of council, occupied he chair until the new President of the Assembly or 1948-49, Dr. E. Marquis of France, was installed.

"Let observation with extensive view, survey ankind from China to Peru." The delegates, lternate delegates and observers from Member edical associations and other bodies were re-eived. The National Medical Associations who re members of the W.M.A. number 25:

Australia, Austria, Belgium, Canada, China, enmark, Eire, France, Great Britain, Greece, Ice-nd, India, Italy, Luxembourg, Netherlands, Nor-ay, Palestine (Arab), Palestine (Jewish), Poland, outh Africa, Spain, Sweden, Switzerland, Turkey nd the United States.

Czechoslovakia notified the council that the ational Medical Association had ceased to exist in 948— and therefore the membership was cancelled. t was regrettable that Dr. Stuchlick, the President lect could not assume his position as President f the Assembly, although he was present through-ut the session in his council seat.

New National Medical Associations elected at is session were Chile, Colombia, Cuba, Dominican epublic, Ecuador, Finland, Hungary, New Zea-nd, Peru, Philippines, Portugal. Applications for embership were received from Bulgaria, Egypt, uatemala, Honduras, Salvador and Pakistan.

Standing orders were received. The Annual eports of Council and Secretary General were ccepted. The Treasurer's report, with balance heet and financial statement for the past year, ith estimates of income and expenditure for the urrent year were presented.

The Headquarters of the Association, after long nd careful consideration of the committee, has een located in the Academy of Medicine Building n New York City. The United States Committee f the U.M.A. has assumed the financial responsi-ility of providing the operating costs of the Head-uarters. Dr. Louis H. Bauer was elected as ecretary-general of the W.M.A. at the council eeting in May. Assistant Secretaries: Dr. Cibrie or Europe, Dr. Bustamante for Latin America, r. Sen for Asia were approved.

The position of observer is a preferred one.

'Tis pleasant through the loopholes of retreat.
To peep at such a world, to see the stir
Of the great babel—and not feel the crowd."

The association is most important and far reach-ng in the potentialities of its constructive work. onferences of this type promote understanding etween individuals and countries. Facts are stub-orn things, one feels there is a long way to travel before one can say "The world is my country—all mankind are my brethren." Obstacles present themselves to block the common purpose of Medical peoples in the world, the high ideals of preventative medicine and good practice with free exchange of knowledge—not least of them is the barrier of language; which magnifies the diversity of ideals and education and makes the machinery of accomplishment cumbersome.

Speeches were limited in time—but were translated into French and Spanish. Minutes and the proceedings were circulated in the 3 official languages. Dr. Gerain Lajoie (Montreal) the official French interpreter, added much to the enjoyment of listening by his excellent translation of French and English.

The Sessions continued from the 8th to the 12th with great seriousness and purpose.

The business included:

A survey of Post Graduate Medical Education and Specialist training.

Report of the Medical Profession in 23 countries.

A study of advertisement and sale of secret remedies and appliances.

Report on unlawful Medical Practices.

Report on Social Security Systems.

A permanent exchange of all scientific journals published by member associations.

The status of doctors in countries where war crimes were practised.

The I.R.O. delegate presented the problem of the settlement of 2,200 refugee doctors in displaced persons camps.

New members of council for 3 years were elected. Dr. T. C. Routley of Canada, Dr. P. Glorieux of Belgium, Dr. John Yui of China.

Dr. Fishbein was elected to produce a bulletin of the W.M.A.

Detailed reports of the business of the meeting will be published in the Canadian Medical Association Journal.

We did not work all the while—we managed to find time to study the beautiful Town Hall where the meetings were held. In the courtway we were struck by the beauty of the Seventeenth century facades. We climbed the cobbled slantway that leads up to the different storeys of the building. Up the cobbled way Church Dignitaries used to ride donkeys and Knights on palfreys rode to their council chambers. The Salle de L' Alabama is the place where the controversy between U.S. and Great Britain over the damage done by the steamship Alabame during the War of Secession was settled in 1872; the Red Cross convention was signed here in 1874. In the Assembly of the State Council are 16th century frescoes of interest.

If you pass through the forecourt of the one time Arsenal the Cathedral of St. Peter is ap-

proached. This edifice was started in 1150. The Chapel was built in 1406—restored in the 19th century. A protestant service has been held at St. Peter's since 1536. Jean Calvin preached here from 1536-1564.

Close by is the Temple de l' Auditoire where John Knox—the Scottish reformer preached from 1555-1557. Along the Rue St. Pierre we see No. 11, the dwelling where Calvin died. Near by No. 40, Grand Rue, the house where Jean Jacques Rousseau was born (1712). We return to the Town Hall via the Old Roman Thoroughfare of Bourg du Forum.

We went by bus to the United Nations Palace—I walked with the Irish delegate Moran who went through the beautiful rooms in silence whilst we all admired the works of art in the spacious halls. When we came out into the beautiful gardens his remark was "Here is where much is done that isn't said and much is said that isn't done." Moran's delightful humour brightened all our gatherings. His anti-communist speech made socialists roar with laughter. His every day remarks were most amusing.

At the International Red Cross Building we viewed the World Central Agency of Prisoners of War and got some idea of the details and intricacies of their useful work.

The State Council and Authorities of the City of Geneva gave us a reception at the Palais Eynard. The official robes were colorful and ornate and fitted well with the beautiful setting.

The official dinner was held at the Restaurant du Vieux Bois near the UNO Building. Even the prolonged official speeches could not dampen the spirit of good will and fun which prevailed among the delegates of all the nations.

We lunched at small Swiss Restaurants with French or Spanish delegates and guessed at the flavour in the excellent Swiss Cuisine.

On September 9th I played truant and joined the excursion planned by the Swiss women. A visit to the Chateau de Chillon, to Montreux along the shore of the Lake of Geneva. The guide at the castle was a young Vancouver girl married to a Swiss and it was a delight to hear her speak of the lives of the Dukes of Savoy, to view their palace, tapestries and dungeons. We came back on a sunny afternoon along the vine-covered roadside with great affection for the little country and its hospitable people.

Another excursion on Saturday afternoon with the ladies—by boat to Castle of Coppet. Here Mme de Staël lived and wrote. There is a beautiful display of old lace.

The excursion on Sunday to Chamonix is memorable for the entertaining companionship of the Swedes and Danes. We visited Tuberculosis Sanitoria and towns. At Passy in the French Alps, the Syndicate des medicine de Haute Savoie and Societe Medical du Plateau had a reception. In Chamonix we were transported by aero car to Planpraz for lunch. Here at a great height we could view the glacier and try to discover Mont Blanc in the white clouds and mists. Heather covered the green slopes of the mountains, the air was rare and fresh as wine. In the Village a festival progressed, the native boys and girls, dressed in quaint costumes, danced to sweet sounds of flutes.

We returned to Geneva to bid farewell at a dinner at the Hotel de la Paix to our Swiss friends. On Monday, September 13, we reluctantly departed from Switzerland to attend the British Commonwealth Council in London at the B.M.A. house in Tavistock Square.

EDITORIAL

J. C. Hossack, M.D., C.M. (Man.), Editor

November and Chiron

One of the faults of our journal (to which, however, no one has so far called attention) is the absence from its pages of verse. This I shall now remedy.

Next was November; he full grosse and fat
As fed with lard, and that right well might seeme;
For he had been afatting hogs of late,
That yet his brows with sweat did reeke and steem,
And yet the season was full sharp and breem
In planting eeke, he took no small delight;
Whereon he rode, not easie was to deeme;
For it a dreadful Centaure was in sight,
The seed of Saturne and fair Nais, Chiron hight.

Thus writeth Spencer on the month we have now entered. Our professional interest is stirred by the reference to Chiron, Aesculapius' preceptor. In old prints we see him with fat November upon his back and in his hand a bow and arrow. How came it so? The centaurs were not all of the same breed. Legend says that they were the ancient inhabitants of Thessaly, the first to tame horses and use them in war. Their neighbours, when they saw them mounted, fled in fear before what they took to be infernal monsters, part men, part horses. But the poets tell another story for they say that Ixion begat them of a cloud which he believed to be Juno. Likewise we are told variously that they were overcome by Bacchus and by Theseus.

However, that may be it has nothing to do with our particular centaur Chiron. He was the son of Saturn and, as Spencer says of Nais, or, as others say, of Phillyra. About these ladies (properly goddesses) I can tell you nothing because about them I know nothing. But the story goes that Saturn became enamoured of the maiden in question and while he was embracing her who should barge in on the tete-a-tete but Saturn's big old wife Ops whereupon Saturn immediately metamorphosed himself into a horse. In due time Phillyra (or Nais) brought forth a creature, in its upper parts like a man and in its lower parts like a horse, and called it Chiron; who when he grew up betook himself to the woods, and there learning the virtue of herbs, became a most excellent physician. For his skill in physic and for his other virtues, which were many, he was appointed tutor to Achilles, instructed Hercules in astronomy (I'll bet you didn't know that Hercules was an astronomer) and taught Aesculapius physic. Unfortunately either before or after his astronomy lectures were finished, Chiron, while handling Hercules' arrows, let one, which had been dipped in the poisonous blood of the Lernean Hydra, fall upon his foot, wounding him incurably. So intolerable were the pains that Chiron cried for death but die he could not for he was born of two immortal parents. But the gods, not closing their ears, translated him into the firmament where he now shines in the constellation Sagittarius and is placed in the Zodiac.

This in short is the story of Chiron and of how he came to be associated with November (the month is in his sign). We should respect him as the grandfather, just as we honour Aesculapius as the father, of medicine. So if at any time when you are practicing "masterful inactivity" and your patient accuses you of "horsing around" just tell him that Chiron would have done the same.

The New Psychiatry

To me at least, and I am sure to many others, the highlight of the recent Convention was the contribution of Dr. Ebaugh of Denver. The new psychiatry could have no more powerful advocate than Dr. Ebaugh for he has a most delightful manner and a personality which invites confidence. There was nothing occult or dry-as-dust in his addresses but, on the contrary, they were given simply, clearly and with many a flash of humour.

Those who missed hearing him speak will have the opportunity of reading his paper in our pages. What I want to mention now is the talk he gave at the dinner of the Neuropsychiatric Section. He spoke then about his subject but chiefly about how his subject is taught in Denver, where, he told us, there is no special course in psychiatry. He had no idea how many hours were directed to its study. Yet Denver graduates must be unique in their training and experience for psychiatry forms an integral part of every clinical subject from the first to the fifth. Thus medical, surgical, gynecological, obstetrical and, indeed, all cases are studied not only from the aspect of the physical condition but also from that of the mental state. Never throughout his whole academic course is the student permitted to forget the complete interweaving of body and mind. He does not learn psychiatry—he absorbs it.

What, I wonder, would Socrates say if he were to see this method of teaching. You will recall how he told his young friend Charmides that the great fault of the doctors of his day was that they separated the body from the soul. Under Dr. Ebaugh's direction that separation has been ended to the infinite benefit of student and patient alike.

Another excellent feature of Denver practice is the assigning of a family to each second year student. For three years each student has a little general practice of one family. He sees its members at home, he learns how they live, work and play. He is on hand whatever may be the ailment and acts as an associate of physician, surgeon or accoucher. For, with his intimate knowledge of each patient as a person, his information can help those responsible for the direct care of each illness. One cannot imagine a better way to stir interest in practice and in people.

The students themselves are not forgotten. We have but to look back to our own student days to admit that to anxieties we were no strangers. Dr. Ebaugh told us that in his school the first year students are encouraged to get forth their own troubles and more than three-quarters of them are found to need help. Such help at such a time is of incalculable value. Not only does it make for happier students but much more effective studiers and workmen. Only one who understands the reasons for his own behaviour is likely to be of help to others, and when understanding is learned early and practiced habitually the benefits to such a doctor's patients must be immense.

Perhaps the most important advance in medicine made during recent years is what one might call the emancipation of psychiatry. For a while it was as guarded, as remote, as inaccessible as are the patients in mental hospitals. It was looked upon as definitely occult, almost obscene; something that could be understood, if at all, by long-haired highbrows who were not able to do much for their patients and who were themselves probably crazy or, at least, a little "tetched."

Now, in the words of Dr. Ebaugh, psychiatry has come "from over the wall" and is mingling with her sister disciplines. No longer is psychiatry something apart from medicine. Now it is medicine and surgery and everything we practice. It is, in fact, the essence of practice with drugs and scalpels merely its assistants. For the aim of everyone is to enjoy life and how can one enjoy it even if his body be healthy unless his mind is at ease? And how can unhappy minds be given ease unless we understand the mechanism of misery and can set that right?

International Medicine

Dr. Anna Wilson, popping about as she does, is by now a familiar figure in the capitals of Europe. Her latest jaunt took her to Geneva and to London where she represented the growing number of medical women first at the meetings of the World Medical Association and later those of the British Commonwealth Council. The success of these meetings was not altogether due to Anna's charming presence but one wonders how the fate of the world might be changed if her attractive and agreeable personality were to permeate the get-togethers of Foreign Ministers and of such like gatherings. Or, rather what would happen if the spirit of harmony, of goodwill, of co-operation, of altruism, of supra-nationalism that made the medical meetings so fruitful, could be brought into the sessions of political leaders.

The hope of the world lies, when one thinks upon the matter, more than ever in our hands. The sufferings of the world are so much due to the perverted ideas of the megalmaniacs. Never before has mankind enjoyed such freedom from the ills of the body. Only we can stop the suffering that comes from disordered imaginations. We have helped to give man a strong body. We have succeeded greatly in fettering his enemy of disease. Now, if to that we can add a healthy mind we can envisage a return of the Golden Age.

The useful and altogether beneficent war against disease is our struggle. On both sides of the iron curtain men and women of humanity and good will strive to better the lot of all, regardless of everything save the needs of those who beg their help. Medicine alone is the universal brotherhood and in it one can find few renegades or traitors. We alone cannot change the face of the world but those who would seek to do so will surely find in us inspiration, example and their chief aid. We are the leaves of the tree that is for the healing of the nations.

In this issue are some notes by Dr. Wilson and I hope to have Dr. Routley's paper delivered at the recent convention for publication also.

Erratum

In the October issue we made the mistake of listing as officers of the G.P.A. the names of those who were properly nominees. I wish to express my regrets to anyone who was embarrassed thereby. In future the General Practitioner's Page will be prepared and edited by one of the officers of their Association. Who the editor will be I do not yet know but any material directed to me will be put into the proper hands.

OBITUARY

Reported by Ross Mitchell, M.D.

Dr. Edward William Montgomery

Dr. Edward William Montgomery, president of the Canadian Medical Association in 1922, died at Winnipeg on Sept. 27, aged 85.

Born in St. Sylvestre, Que., he was educated at Inverness Academy and moved with his parents to Stonewall when he was thirteen. Graduating in Arts from Manitoba College in 1886, he taught at Brandon, then entered upon the study of medicine and received his M.D. degree in 1892. Beginning practice in Winnipeg, he taught continuously from October, 1892, to April, 1927. When Manitoba Medical College was reorganized as the Faculty of Medicine, University of Manitoba, he became the first Professor of Medicine, and held that position until 1927 when he was elected to the legislature and became the first Minister of Health and Public Welfare, the combination being in itself an innovation. He resigned his teaching post, but was appointed Professor Emeritus of Medicine and received the LL.D. degree from the University of Manitoba.

His ministerial duties were heavy since he had to integrate services formerly administered by other departments and in consequence much legislation had to be introduced. Inspired by the memory of his friend, the late Dr. Gordon Bell, Dr. Montgomery brought to the administration of his department the same qualities of mind and heart which had raised him to leading rank in his profession. Fired with the zeal of a crusader he insisted on a programme of immunization of school children which in three years resulted in a reduction of 50 per cent in diphtheria. He was interested in the problem of maternal mortality and established the first Health Unit in the province. During his term of office, a diagnostic tuberculosis clinic was established in Winnipeg, a tuberculosis sanatorium was opened in St. Vital, the Cancer Relief and Research Institute was set up and modern buildings were erected at Brandon and Selkirk Mental hospitals. A provincial epidermiologist was appointed, and an attempt was made to deal with industrial hazards such as silicosis among miners. To get first hand knowledge of northern Manitoba, he made a trip to Churchill, largely by canoe, and described the rocks and rivers of the North in two articles in the Manitoba Medical Bulletin as only a scientist and lover of nature could.

The rough and tumble of parliamentary debate was not congenial to him and he retired in 1932 to the chairmanship of the Board of Health, a post which he held till his death.

No account of his life would be complete without reference to his efforts to combat tuberculosis. He was one of the prime movers in the institution about 1908 of the Sanatorium Board of Manitoba; he served as chairman of the Board from 1916-1918, and he remained a member until his death. He was deeply concerned with the high incidence of the disease among the Indians of northern Manitoba.

His published writings included Studies in Pernicious Anaemia, Memorial sketches of Gordon Bell and J. W. Good, Maternal Mortality, Tuberculosis in Northern Manitoba, and the first David A. Stewart Memorial Lecture.

He is survived by his widow, three daughters and two sons.

Though he had a large and important private practice, his true vocation was public health and his avocation the study of nature. He had a fine garden at his summer home by the Red River, north of Winnipeg and a fruit grove in southern California. A singularly keen and analytical mind and an impelling energy made him a leader in many fields.

BOOK REVIEWS

Books to Read and Recommend

We have received from the McGraw-Hill Company two very interesting and useful books. Both are written for lay readers but, as is not infrequently the case with such books, they are not unfitted for professional reading. Books of this sort can serve the very useful purpose of emphasizing and enhancing advice given in the consulting room, for the patient can, at his leisure, inform himself more fully upon points discussed and thus the doctor's suggestions are reinforced to the advantage of adviser and advised alike.

You Must Relax

One of the commonest orders given by doctors to their patients is "you must relax." But many patients find this exceedingly difficult and doctors themselves are hard put to it to give these patients clear instructions on the technique of relaxation. Herein lies the value of this 254-page book. It gives clear directions on how to relax not only when lying down but also while active. The author takes the need of relaxation seriously. Abnormal tension is universal in every walk of life and its continued maintenance paves the way to dissatisfaction and disease. He seeks, therefore, to teach a method which will make relaxation a habit. He insists that work of all sorts can be done better and more easily if tension is absent, and he is satisfied

that, by practice of his technique it can be abolished.

The book is a presentation, in popular language, of the author's "Progressive Relaxation"—a book addressed to medical readers. In the present work he considers the nature and mechanism of tension, following which he gives careful, precise instructions on the technique of relaxation, introducing a number of photographs to aid the reader.

The author was formerly attending physician on the Michael Reese Hospital and Research Association and Assistant Professor of Physiology at the University of Chicago. At present he is director of the Laboratory for Clinical Physiology in Chicago.

To doctors the book has a two-fold value. First they can apply its teachings to themselves and second they can put in their patient's hands the instructions which they have not time to detail. There are chapters on fears and worries, on sleeplessness, on indigestion, on high blood pressure and on a number of other everyday complaints. In these chapters the writer gives reassurance and explanation which supplements the advice given in the consulting room and shows the patient how to help himself and, incidentally, how to collaborate with his doctor.

The book costs $2.50 and will be sent on approval. YOU MUST RELAX, a practical method of reducing the strains of modern living by Edmund Jacobson, M.D. Revised Edition, Toronto. McGraw-Hill Company of Canada Ltd, 12 Richmond St. East, Toronto 1.

"The Years After Fifty." One does not have to be fifty to enjoy this book but everyone over fifty can read it with both enjoyment and profit. It is written in a pleasant, easy, optimistic style which holds the reader while his fears and misapprehensions are being reasoned away. It is a book par excellence for those who fear their fifties. It discusses the "bugaboos of age" — the ailments to which man is then prone—but gives excellent advice on how these can be caught before they become mischievous. It tells how to use to the full advantages that age brings. It deals with amusements and hobbies and such death-postponing activities. It teaches its readers how to stay young, active and satisfied despite the calendar.

It is therefore a very good book to advise one's elderly patients to read. It won't make doctors out of them—just better and longer living patients. The author makes his reader feel that there is a man who himself has passed his fifties and still finds life thrilling, interesting, productive. There is a lot of excellent philosophy in his pages which, when applied, will help the reader to get much more "life" out of the years after fifty.

The Years After Fifty: Wingate M. Johnson, M.D. Professor of Clinical Medicine, Bowman Grey School of Medicine of Wake Forrest College; with a foreword by Morris Fishbein, M.D., McGraw-Hill Co., Ltd., 12 Richmond Street East, Toronto 1, Ont. $2.50. (Will be sent on approval if requested).

Chronic Ill Health is the title of a hundred-page book by Rosa Ford.

Its substance is that much chronic ill health is due to infection of the para-nasal sinuses and can be remedied by the drainage of these sinuses. The author who was lately attached to the South London Hospital for Women has been impressed by the role of sinus infection in ailments of many sorts and during the past twenty years has gained a wide clinical experience, and has evolved a successful treatment. To be successful, however, she insists that every case must be given close and individual attention. The conditions considered in separate chapters are: Chronic Headache and Migraine; Chronic Ill-Health; Eye affections due to Para-nasal Sinusitis; Rheumatoid Arthritis; Disseminated Sclerosis; Duodenal ulcer; Coronary Embolus; Tic Douloureux; Vertigo; Acne; Uterine Disorders; Obesity; Hay Fever. Separate chapters are given to Diagnosis, Etiology, Pathology and Treatment.

Treatment is by methods which have been gradually evolved "through arduous experience of many years." The author, for purposes of close observation, had several of her patients live in her own house. The methods are five in number four of which are non-surgical. They aim at promoting prompt drainage and ultimate healing of a condition which she regards as essentially an abscess.

Some cases are described in detail, others are considered more briefly. The results as given prove the author's success in treatment. Dr. Ford admits that "the reader will find much to criticise" in her book but she begs him to over look its faults and to give her techniques a reasonable trial.

Chronic Ill Health, relieved by drainage of the para-nasal sinuses; by Rosa Ford, M.B. (London), D.O. (Oxon), late Ophthalmic Surgeon to the South London Hospital for Women; 104 pages, with 13 illustrations; London, Henry Kimpton, 25, Bloomsbury Way W.C. 1. Price 6/6 ($1.30).

SOCIAL NEWS

Reported by K. Borthwick-Leslie, M.D.

And so another highly successful Manitoba Medical Convention has come and gone, leaving an aftermath of renewed friendships, "bucked up" scientific interests, memories and the old hangover. It was very nice to hear one Montreal Drug Detail man remark, "Well, conventions are conventions, but the Manitoba one is still the best."

♦

For those who were not in attendance I would like to report that the Medical Defence Dinner at the R.C.A.F. Officers' Mess was an unqualified success. Air force hospitality and courtesy has always been famous. It was grand to renew acquaintance with so many of the Military, and my privilege to "launch" Dr. Christina Curran as Capt. R.C.A.M.C. back to Winnipeg social life. Some of the stories were unique to say the least —but entertaining! On the more serious side was the report of Lt.-Col. G. L. Morgan-Smith, Command Medical Officer, Prairie Command, who was just back from a one week's course in Washington on the medical aspects of the Atomic Bomb. Quote "In this time the basic background of nuclear physics was well covered to make it more or less understandable to medical officers. First hand accounts of the three experimental trials and the military use in Japan were discussed. The pathology and treatment of radiation damage were well presented, and the work being done on medical research. It was also pointed out that the Japanese who recovered from radiation illness are now wholly well, and a marked contrast to the individuals who had injuries from burns and flying masonry. Evidence of permanent sterility, and mutation of the genes has not been found."

♦

A point of interest was the stress laid on the fact that a great bulk of the casualties from the bombs in Japan were of the same nature as from bomb damage as we knew it in Europe. Radiation injury did not effect more than 15% of the casualties, as the radioactive cloud of dust was borne upward and dissipated in the air. There was no damage to the rescue teams in entering the bombed area, but rather total destruction of all services and hospitals, and lack of organization of rescue work due to the massive devastation.

♦

Also of interest to all old friends and rugby fans in Manitoba, will be the arrival of twins, Carey and Curtis, in Phoenix, Arizona. The proud parents, Dr. and Mrs. Arthur C. Stevenson—"Art" to you.

Speaking of the "Women" the medical undergrads had their annual "Freshman" Banquet and Initiation at the Marlborough, Tuesday, the 26th. A grand turn out of students, grand students, too, and a lovely evening, but alas, a very poor showing of the "old girls"—Anna Wilson, in her usual entertaining manner, took us to Geneva and back, very instructive, amusing and awe inspiring.

♦

Welcome from Canada, Manitoba and Winnipeg, to Dr. John Christopher Colbeck, born in Hull, England, who has come to us to direct the Provincial Laboratories. Dr. Colbeck received his training at Guy's Hospital, London, with research work in Treiburg, Germany, followed by a fellowship at Cambridge — war work, pathology work at Warwickshire and Yorkshire. An excellent record, but frankly I think a bit overzealous in his research work, catching our pet impetiginous, abscess bugs himself.

♦

No wonder Thor looks a bit worn—Three strenuous months of holiday travel in Iceland, England, Scotland, France and all Scandinavia, to return to work, Medical Conventions, and that all important occasion, daughter Tannis' wedding to Geo. Taylor Richardson. The wedding took place October 30th in Westminster Church at 8.00 p.m. Bermuda, I understand, is the background for the wedding holiday.

♦

Friday evening, October 22nd, a delightful dinner was held at the home of Dr. Anna Wilson in honor of Dr. Anna Nicholson, Saskatoon, the President of Canadian Federation of Medical Women. The Western members of the Federation Executive were present and plans begun for the year's activities including the C.M.A. and Federation Annual meetings in Saskatoon next June.

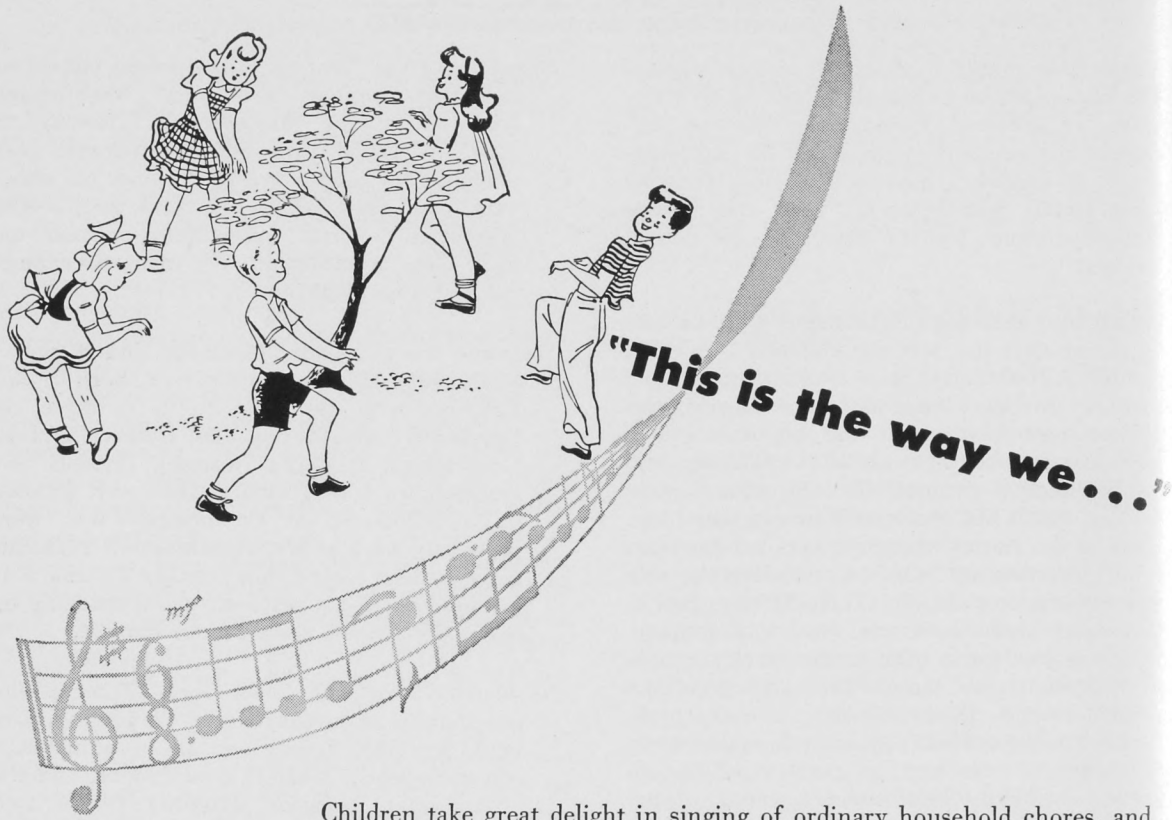
♦

The shock of Dr. J. D. McQueen's death is beginning to pass off, but the loss of his guiding hand, friendly personality, charming, dry humor, superlative scientific and professional ability as teacher, doctor, and friend never will. Sincere sympathy to Mrs. McQueen and family and friends.

♦

How proud our friend and confrere, Dr. A. Blondal, would have been of his first grandson, August Theodore, also born this month, and a great little fellow he is. Congratulations to Al and Marjorie.

(Continued on Page 625)



Children take great delight in singing of ordinary household chores, and they're just as joyous about taking a multiple vitamin preparation—when it is *Vi-Daylin*. They like Vi-Daylin's sweet, citrus fruit-like flavor, the clear lemon color of the liquid—so easy to swallow they often ask for more. However, Vi-Daylin is concentrated. One serving a day is usually enough for the average child. For children up to 12 years of age a single teaspoonful (5 cc.) of Vi-Daylin supplies twice the minimum daily requirements of vitamins D and C and thiamine, the full minimum daily requirement of vitamin A and supplemental amounts of riboflavin and nicotinamide. Vi-Daylin is suitable for infants, too, since it is virtually free of alcohol (less than 0.5%) and mixes readily with milk and other foods. Mothers appreciate the convenient bottle-to-spoon administration, and the economy of the single multiple vitamin preparation. On your next prescription for a multiple vitamin product, please your little patients, and their mothers, by *specifying* Vi-Daylin; available at prescription pharmacies everywhere in 90-cc. and 8 oz. bottles. ABBOTT LABORATORIES LIMITED, Montreal.

SPECIFY **Vi-Daylin**

TRADE MARK

Vitamins A, B_1, C, D, Riboflavin and Nicotinamine in palatable liquid form

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Manitoba Medical Association Committee Reports

Report of the Executive Committee

To the Executive Committee and Members of The Manitoba Medical Association:

1. Date of Annual Meeting.

The date of the Annual Meeting is usually determined by the western itinerary of the C.M.A. officers and speakers. It is unfortunate that departure from that routine prevented us from having Doctors L. Berger, E. F. Brookes and A. D. MacLachlin, but we welcome the President and General Secretary, C.M.A., also Dr. F. G. Ebaugh of Denver, Colorado, and Dr. J. L. McKelvey of Minneapolis, Minn., as guest speakers.

2. Executive Committee.

The last report of the Executive Committee covered the period from October, 1946, to June, 1947, at which time a short business session was held in conjunction with the 78th Annual Meeting of the Canadian Medical Association. The adjourned Annual Meeting was held on the evening of October 15th. There have been 10 meetings of the Executive Committee, with an average attendance of 15, and three interval meetings of the Officers. In addition, personnel of several special committees have given unstintingly of time and effort.

3. Office Space.

Since January 31st, 1948, increased office accommodation has been available by use of the full suite at 604 Medical Arts Building. Accommodated in the office at the present time are the Manitoba Medical Association, the College of Physicians and Surgeons of Manitoba, the Winnipeg Medical Society, and the Manitoba Medical Review. In common with other tenants, rent was raised 10% during the year.

4. Secretarial Help.

With the consolidation of the office work, there was amalgamation of the Association and College Staffs, and the present staff consists of three permanent employees.

5. Chairman of the Executive Committee.

No appointment was made to this office, but a Chairman was appointed by the President for each meeting. Since the appointment of a full-time Executive Secretary, the need for the Chairman of Executive is less apparent, and amendment to the Constitution in this respect will be placed before the Meeting.

6. Membership.

It is a pleasure to report that membership continues at a high level. Several members who enjoyed complimentary membership have left the province, but the majority of those remaining are active members.

7. College of Physicians and Surgeons.

The resignation of Dr. W. G. Campbell left the C.P. & S. without a Registrar. A negotiating committee had been drawn up to further the interest of the profession by a closer working arrangement of the College and the Association. As a result of negotiations, the Executive Secretary was appointed Registrar, and the arrangement reached whereby a monthly sum would be paid by the College to the Association to cover the cost of secretarial help, rent, light, phone, etc.

8. Workmen's Compensation Board.

The proposals of a new fee schedule were presented by the Negotiating Committee to the W.C.B. in September, 1947. Counter proposals were not received until May, and were incomplete. A meeting of the Committee and Board was called for September 22nd, and additional proposals were received on October 7th. Another meeting was scheduled for October 15th, when it was hoped proposals might be available for presentation to the Meeting.

9. Constitution and By-laws.

Extensive revision of the Constitution and By-laws was undertaken by the Committee and will be presented, in separate copy, for consideration of the meeting. Method of nominating the representative to the C.M.A. Executive, and of convening the provincial Nominating Committee, also the manner in which changes may be made in the constitution, are outlined.

10. District Medical Societies.

Last year each District Medical Society was requested to apply for speakers through the Executive Secretary in order that the selections might be made by the Extra Mural Committee. The arrangement has worked very satisfactorily this year and ensures that the honour of being chosen speaker is more evenly distributed among the members of the profession. It is hoped that in the near future all requests will be handled in this manner.

11. General Practitioners' Association of Manitoba.

During the year the General Practitioners' Association of Manitoba was formed, and application for recognition as a section was granted. The aims and objects of the Association are as follows:

(1) To guard the rights of the public so that the services of the general practitioner or family doctor will not disappear.
(2) To guard the rights of the general practitioner so that the high standard of service will be maintained.
(3) To work in co-operation with all organizations of the medical profession.

Several matters of importance to the group are—availability of hospital beds, equalization of M.M.S. fees, facility for additional study and research for the G.P., and social get-togethers. At the C.M.A. meeting in June, provision was made for a G.P. Section, and provincial representatives have been named to the Steering Committee.

12. Manitoba Medical Review.

Once again the Editor, his assistant, heads of the various departments and Business Manager, are to be congratulated on the success of their efforts. The constant appeal of the Editor is for copy, to be in his hands by the 10th of the month preceding that in which the article is to appear, which will ensure publication of the Review earlier in the month than has been possible during the past year. Team work in this respect is essential. A contract with the Business Manager for a period of two years beginning January, 1949, has been consummated by the Executive.

13. Professional Directory.

In his dual capacity the Executive Secretary has had frequent written communications from and personal interviews with prospective applicants from other parts of Canada and the United States, Great Britain and Europe. Several inquiries are received weekly, and every attempt is made to bring available openings to the attention of interested applicants.

14. Legislation.

Draft copies of legislation were received from the Hon. Minister of Health and considered by the Committee of Fifteen which was attended by the Deputy Minister on Feb. 26th, 1948. Assistance of the Association was requested by the Manitoba Branch, Canadian Physiotherapy Association, in connection with a proposed private bill to license Physiotherapy and Massage Practitioners. The bill was withdrawn and an amendment of the Public Health Act provided for the licensing of these groups. Regluations have not yet been promulgated.

15. Manitoba Medical Service.

A considerable portion of the adjourned Annual Meeting in October, 1947, was spent in consideration of the profession-sponsored plan for providing prepaid medical care in this prov-

ince. Suggestions proposed by the Board for the improvement of Plan "B" were approved by the meeting.

The balance of the original loan was repaid in full during the year.

Progress was made in the definition of a specialist, and dual specialty in unrelated lines was discontinued. Salary limitations were raised to include, single $2,400.00, married $3,000.00, married with family $3,600.00, subject to ratification by the Annual Meeting.

Dr. T. D. Wheeler was appointed by the M.M.S. to represent this Province at a meeting called for October 13th and 14th in Toronto to discuss formation of a federal plan to co-ordinate existing provincial schemes.

Dr. J. C. MacMaster is the new Medical Director, replacing the veteran Dr. E. S. Moorhead, who gave freely of time and effort on behalf of the profession.

16. Committee of Six.

At the time of the Annual Meeting in June, 1947, exception had been taken by the profession to the signing by prospective medical students of a form indicating willingness to practice in the Province for 5 years following graduation. A meeting, held on June 25th, included members of the Cabinet, Board of Governors and Association. It was decided that the plan was unworkable, and that other measures should be taken to secure medical men for rural areas.

Only two meetings of the committee, or of a sub-committee, have been called and the number of available openings for General Practitioners has been reduced from 125, notified in the Rockefeller Report, to 20, of which only 3 or 4 are bona fide requests.

17. Committee on Economics.

Several items of importance came under the attention of this committee during the past year, viz: Dominion-wide tariff study by C.M.A., Contract Practice in relation to Manitoba Medical Service and Industrial Companies, Negotiations with Workmen's Compensation Board, Dominion Health Proposals, Municipal Doctor Contract.

18. Fee Schedule Revision.

At the request of the Manitoba Medical Service, a committee composed of representatives from each body was appointed to clarify the application of the Minimum Schedule of Fees for use of the Manitoba Medical Service. After four meetings, the committee had considered the M.M.S. proposals, but those of the Paediatric and General Practitioner groups were held in abeyance until some decision of the proposed equalization of fees might be obtained.

19. Cancer.

The report of the Special Select Committee of Legislature reported that the Union of Municipalities were seeking extension of the Cancer Relief and Research Institute facilities to include the diagnosis of Cancer. More recently, resolutions of the Women's Institutes of the Province have called for similar action.

20. Group Insurance.

With the appointment of committees at the beginning of the present year, one was named to study and report on the possibility of securing a policy of insurance against accident and illness hazards which would appeal to all members of the profession, young and older alike. A more complete report will be presented for consideration of this meeting.

21. Advisory Commission Under the Health Services Act.

The three-year term of Dr. H. S. Evans was renewed in 1947 and that of Dr. A. Hollenberg in 1948 on the nomination of the Executive Committee.

23. 79th Annual Meeting, C.M.A.

The meeting was held in the Royal York Hotel, Toronto. Executive Committee on June 18th and 19th. General Council on June 21st and 22nd, and the General Meeting, with scientific sessions, on June 23rd, 24th and 25th. At the installation ceremony on June 23rd, senior membership was conferred on Doctor William Gardner of Winnipeg. The following Manitoba representatives to General Council attended: Doctors R. W. Richardson, H. S. Evans, A. M. Goodwin, C. B. Schoemperlen, A. Hollenberg, J. R. Martin, M. T. Macfarland, E. F. E. Black, Anna Wilson, V. F. Bachynski, Q. D. Jacks.

A meeting of General Practitioners was convened on June 23rd, and preliminary plans were made for the formation of a General Practitioner Section within the structure of the C.M.A.

The federal proposals for Health Plan were discussed at some length and Divisions were requested to offer co-operation to the provincial Departments of Health which would be administering the grants.

It was announced that reasonable deductions would be allowed in connection with expenses of members of the profession attending the meeting of the C.M.A., a provincial division, and one specialist section, during the year. Thus the efforts of the parent body under the stimulus of the provincial divisions have achieved results.

International medicine has recently come greatly to the fore with formation of the World Health Organization, and World Medical Association. Dr. T. C. Routley has played a great part in the organization of these bodies, and was to attend the meeting of the W.M.A. in Geneva in September. Dr. F. G. McGuinness was named to accompany him, but when he was unable to accept the appointment, Dr. J. F. C. Anderson, President-elect of the C.M.A., was named as alternate. Dr. Anna Wilson, Secretary of the Federation of Medical Women of Canada, was named as an observer, and was to attend the British Commonwealth Medical Association meeting in London following that of the W.M.A.

24.

The genuine interest in the affairs of the Association, by officer and individual members of the Executive Committtee, has been commendable.

Respectfully submitted.

R. W. Richardson,
President.

A. M. Goodwin,
Honorary Secretary.

Report of the Honorary Treasurer

To the President and Executive of
The Manitoba Medical Association:

25.

Herewith certified financial statement from our auditors, Messrs. Thornton, Milne & Campbell.

All of which is respectfully submitted.

C. B. Schoemperlen,
Honorary Treasurer.

9th October, 1948.

To the Members,
Manitoba Medical Association,
Winnipeg, Manitoba.

Dear Sirs:

We have completed our audit of the books and accounts of your Association for the period **from 1st June, 1947, to 30th September, 1948,** and submit herewith our report thereon, together with the following relative financial statements:

EXHIBITS:

"A" Statement of Assets and Liabilities as at 30th September, 1948.

"B" Statement of Revenue and Expenditure from 1st June, 1947, to 30th September, 1948.

The excess of Revenue over Expenditure, as set forth in Exhibit "B," amounted to $2,286.81. Membership fees received are in accordance with duplicate receipts on file and were reconciled with the membership cards issued. In accordance with the minutes of the meeting held on the 13th of December, 1947, the sum of $175.00 per month has been received from the College of Physicians and Surgeons covering their portion of the general office expenses. The monies received from the Canadian Medical Association represent repayment in full of a $1,000.00 grant made to the Canadian Medical Association Entertainment Committee in the previous period, in addition to $99.50 covering payment of secretarial services rendered at the Canadian Annual Meeting. The receipt of $600.00 from the Manitoba Medical Service constituted the final payment on a $1,000.00 loan made to this body in previous years. All expenditures have been properly authorized and satisfactory vouchers were produced for our inspection.

Relative to our examination of the various items comprising the Statement of Assets and Liabilities, marked Exhibit "A," we would comment as follows:

CASH ON HAND AND IN BANK, $5,434.70: We did not count the cash on hand. The cash in bank was reconciled with a certificate received from the Bank of Montreal, subject to an allowance for outstanding cheques amounting to $645.44 as shown by the books.

ACCOUNTS RECEIVABLE, $1,392.17: Accounts Receivable on behalf of the Review are considered to be fully collectible. The amount owing from the College of Physicians and Surgeons represents expenditures made by the Association on behalf of Extra Mural Services.

INVESTMENTS, $10,066.94: We examined the bonds comprising this asset and found same to be in order. During the period, the Province of Manitoba 4% 1947 bonds were redeemed, the profit on same being reflected in Exhibit "B." The proceeds of the redemption were reinvested in Dominion of Canada 3% 1966 bonds. The market value of the investments at the present time is $10,546.00; this represents an appreciation in value over cost of $479.06. All interest has been duly accounted for on a received basis.

DEFERRED INCOME — EXHIBITORS' DEPOSITS, $1,084.03: This item is comprised of receipts from Exhibitors less expenses incurred to date in connection with the 1948 Annual Meeting. It was deemed advisable to defer these monies until such time as the final financing of the Meeting had been completed.

In conclusion, we wish to report that we found the records satisfactorily kept and that all our requirements as auditors have been complied with.

Yours very truly,

THORNTON, MILNE & CAMPBELL,

Chartered Accountants.

Exhibit "A"

26. Statement of Assets and Liabilities As at 30th September, 1948

ASSETS

Cash:			
Petty Cash on Hand		$ 20.00	
Bank of Montreal		5,414.70	
			$ 5,434.70
Accounts Receivable:			
Review Advertisers		$ 849.74	
Advance Expenses paid on Review		298.55	
College of Physicians and Surgeons		243.88	
			1,392.17
Investments:			
	Par	Cost	
Province of Manitoba			
4½%, 1956	$2,000.00	$1,957.12	
Canadian National Railway:			
5%, 1969	1,000.00	1,086.07	
Dominion of Canada:			
3%, 1951	2,000.00	2,000.00	
3%, 1952	2,000.00	1,975.00	
3%, 1957	1,000.00	1,000.00	
3%, 1959	500.00	500.00	
3%, 1963	500.00	500.00	
3%, 1966	1,000.00	1,048.75	
			10,066.94
Office Furniture and Equipment		$ 487.37	
Less: Reserve for Depreciation		487.37	
			$16,893.81

LIABILITIES

Accounts Payable:		
Dr. J. C. Hossack—Honorarium		$ 450.00
Deferred Income:		
Exhibitors' Deposits		1,084.03
Surplus Account:		
Balance as at 31st May, 1947	$13,072.97	
Add: Excess of Revenue over Expenditure, as per Exhibit "B"	2,286.81	
		15,359.78
		$16,893.81

Exhibit "B"

27. Statement of Revenue and Expenditure From 1st June, 1947 to 30th September, 1948

REVENUE

Fees Collected:		
457 Members at $27.00	$12,339.00	
153 Members at 7.00	1,071.00	
57 Members at 11.50	655.50	
6 Members at 24.00	144.00	
4 Members at 13.50	54.00	
3 Members at 4.00	12.00	
2 Members at 15.00	30.00	
1 Member at $3.00 (token payment)	3.00	
		$14,308.50
College of Physicians and Surgeons		1,925.00
Canadian Medical Association		1,499.50
Winnipeg Medical Society		1,200.00
Manitoba Medical Service		600.00
Interest on Bonds		450.12
Sale of Doctors Lists		56.00
Profit on Sale of Bonds		24.69
		$20,063.81

EXPENDITURE

General Expenses:		
Salaries:		
Dr. M. T. Macfarland	$8,000.00	
H. M. Brown	2,005.00	
I. Allison	1,307.50	
B. J. Wright	1,194.50	
G. V. Peck	135.00	
Sundry	206.64	
Unemployment Insurance	47.19	
		$12,895.83
Rent		1,678.69
Dr. Hossack—Honorarium		800.00
Printing, Postage and Stationery		644.08
Office Furniture and Equipment		283.50
Telephone and Telegraph		239.28
Miscellaneous Expense		198.84
Business Taxes		194.68
Audit Fees		100.00
Light		72.84

Advertising	63.51	
Bank Loan Interest	41.57	
Bank Charges	36.15	
Machine Servicing	26.81	
Legal Expense	25.00	
Bond on Treasurer	5.00	
		$17,305.78
Travelling Expenses		163.92
Annual Meeting		163.55
Entertainment		103.50
Executive Luncheons		40.25
		$17,777.00
Excess of Revenue over Expenditure for the period		2,286.81
		$20,063.81

Report of Membership Committee

To the President and Executive of
The Manitoba Medical Association:

28.

I wish to present the following report to date:

There are 727 Doctors in the Province of Manitoba	500	Winnipeg
	227	Rural
649 Active paid-up Members	464	Winnipeg
	185	Rural
7 Senior Members	4	Winnipeg
	3	Rural
2 Associate Members	2	Winnipeg
98 Membership Fees Unpaid	49	Winnipeg
	49	Rural
756		
29 of those members who have paid fees have left the city during the year, or are deceased.		
727 Total		

29.

This represents a total membership as at September 30th of 87%. Of the 98 doctors whose fees are unpaid, 35 are retired or over 70 years of age and doing a very limited amount of practice. 11 are quite recent registrants in the province and every effort will be made to bring them into membership in 1949.

Deducting the above mentioned from the 98 unpaid memberships would leave only 52 unpaid collectible fees, increasing the percentage of paid-up membership to 93.1%.

Of the 236 Complimentary Memberships granted to doctors demobilized from the Armed Services in 1947, 177 have become active paid-up members, 50 have left the province and 9 have not paid fees.

Seventy-eight members have been lost to us during the year, 62 having left the province and 16 are deceased.

Thirty-nine new members have been enrolled to date this year.

The co-operation of all members in bringing the membership to an all-time high is greatly appreciated. It is hoped that this can be continued.

Respectfully submitted.

C. B. Schoemperlen,
Chairman.

Report of Committee on Economics

To the President and Executive of
The Manitoba Medical Association:

30.

The Committee on Economics has dealt with three problems in the past year, viz.: Contract Practice, Municipal Practice and the Need for General Practitioners in Rural Manitoba.

Contract Practice: The practice of individual doctors, or groups of doctors, taking on groups of individuals, or societies, or industries, for general care on a prepaid basis, was brought before the Committee on Economics because of complaints registered by individual practitioners that this method of practice was interfering with their livelihood and also placing a great handicap in the progress of our mutual endeavor, viz.: the Manitoba Medical Service. This was dealt with by the Economics Committee and referred to the Executive of the Manitoba Medical Association. It was felt that contract practice had gone on so long in our profession that it would be impossible, except by mutual consent, to prevent individual practitioners, or groups of practitioners, from taking on such contracts. On the other hand, it was also felt that, when such contracts competed with the coverage given by the Manitoba Medical Service, it was inconsistent for such doctors who have private contracts to partake of the benefits of the Manitoba Medical Service. Following this, the matter was taken up by the Manitoba Medical Service and they forwarded a letter to all its medical members, indicating that on and after April 20th, 1948, any physician, or group of physicians, in taking on a contract for general medical coverage, which could be conceived as competing with the Manitoba Medical Service, would give sufficient grounds for exclusion of such doctor, or doctors, from medical membership in the Manitoba Medical Service. This, however, solves the immediate problem but it does not solve the long-term problem of contract practice and all that it entails. It was felt by your committee that, if any steps are to be taken to regulate and control contract practice it would be advisable for such a move to come from the general meeting of the Manitoba Medical Association and any instructions that this meeting will give for its investigation and its solution.

31.

Municipal Contracts: Last year this committee presented before this meeting a medical contract for municipal physicians with stipulated salaries, holidays, pension and sickness benefits. Of all the municipal doctors practicing under contract only one such practitioner has availed himself of the benefits of this contract. All the others, for various reasons, have found it more expedient to continue on the old basis in which there are no such safeguards. It seems to your committee that the reason for this reluctance to accept the new contract lies in the fear of competition by other practitioners and also in the fear that municipalities may cancel their contracts and open up practice on a basis of free enterprise. It seems also to your committee that the practitioners whom we have so carefully safeguarded have acted in a manner that is both against their own benefit and also in such a way as to make the committee feel that its efforts were wasted. The principles have been disregarded and they have been motivated by a short term view of the situation and their own fears of security. Certainly we cannot make progress along these lines other than by regarding principles alone and disregarding personal considerations.

Need for General Practitioners in Rural Manitoba: You will remember that in the Rockefeller Report, published last year, regarding medical care in Manitoba it was pointed out that Manitoba had openings for 240 practitioners. Your representatives on the Health Services Act Commission insisted that these openings be listed as to opportunity of making a living, proper facilities for practice and for residence. Manitoba was surveyed by two teams of laymen, appointed by the Department of Health, and in the September meeting of the Commission these investigators found only 4 or 5 openings which will fulfil these criteria, indicating that the hue and cry for general practitioners in rural Manitoba was more hysterical than practical.

All of which is respectfully submitted.

A. Hollenberg,
Chairman

Interim Report of Workmen's Compensation Board Negotiating Committee

To the President and Executive of
The Manitoba Medical Association:

32.

Despite the fact that to date a definitely revised fee schedule has not yet been agreed upon, considerable progress has been made. The Negotiating Committee submitted a fee schedule to the Workmen's Compensation Board in August, 1947. The Board studied this schedule and made a counter proposal, which, while not being entirely acceptable to the committee, is nevertheless an improvement over the existing fee schedule.

The Board's proposed schedule has again been studied by the committee, and a joint meeting of the Board and the committee is scheduled to take place on September 22, at which time it is hoped the existing differences will be ironed out.

The committee is, however, not only concerned with the fee schedule. It is felt that the regulations, too, require revision and an attempt will be made to have them revised at the joint meeting.

If all goes according to plans, a revised schedule, acceptable to both parties, will be ready for the Annual M.M.A. meeting in October.

Respectfully submitted.

H. Funk,
Chairman.

Report of Workmen's Compensation Board (Referee) Committee

To the President and Executive of
The Manitoba Medical Association:

33.

I beg to present herewith a summary of the Committee's activity for the year ending October 1st, 1948.

The committee was convened on eighteen (18) occasions, seventeen (17) times for general cases, once for an ophthalmic case. A total of forty-nine (49) patients were reviewed.

On several occasions professional fees were assessed. It is hoped that the forthcoming amended scale of fees will go far to reduce or even obviate the necessity for such reviews.

Respectfully submitted.

C. E. Corrigan,
Chairman.

Report of the Legislative Committee of Fifteen

To the President and Executive of
The Manitoba Medical Association:

34.

A meeting was attended on the 26th of February, 1948, at which the Deputy Minister of Health met the Committee of Fifteen and outlined and discussed proposed changes in medical legislation.

Considerable attention was paid to the recent session of the Legislature with particular reference to private Bills to be introduced.

Changes in Existing Medical Legislature

1. An Act to Amend the Tuberculosis Control Act. This repealed the establishment of the Tuberculosis Control Commission and transferred the powers of the Commission back to the Sanatorium Board of Manitoba.

2. An Act to Amend the Health Services Act. These changes were generally administrative and were not considered to be controversial.

3. An Act to Amend the Vital Statistics Act. Minor changes were made regarding the recording of children either adopted, or registered as legitimate.

4. An Act to Amend the Health and Public Welfare Act. 19 separate Acts as listed, and all matters dealing with the regulations made under any of these Acts were to be under the control of the Minister:

(1) The Anatomy Act.
(2) The Basic Sciences Act.
(3) The Cancer Relief Act.
(4) The Child Welfare Act.
(5) The Frozen Food Locker Plant Act.
(6) The Health Services Act.
(7) The Hospital Aid Act.
(8) The Licensed Practical Nurses Act.
(9) The Lunacy Act.
(10) The Marriage Act.
(11) The Mental Deficiency Act.
(12) The Mental Diseases Act.
(13) The Old Age and Blind Persons' Pensions Act.
(14) The Manitoba Physical Fitness Act.
(15) The Private Hospitals Act.
(16) The Public Health Act.
(17) The St. Boniface Home for the Aged and Infirm Act.
(18) The Tuberculosis Control Act.
(19) The Vital Statistics Act.

5. An Act to Amend the Hospital Aid Act. These amendments provide that the rates in respect of public ward patients and babies shall be fixed by Order-in-Council in place of such rates being fixed in the statute as at present.

6. An Act to Amend the Marriage Act. This merely alters the regulations regarding a non-resident who desires to be married in Manitoba and who produces a report of a serological test from an approved laboratory.

35.

Two private Bills were apparently due to come up although at the time of our meeting with the Deputy Minister, no information was available.

The first was a Bill for the licensing of optometrists. This was subsequently dropped.

The second Bill, an Act respecting the practice of physiotherapy and massage, was introduced by Mr. Turner and received first reading. This Act was patterned after a similar Act in British Columbia, but differed in the one important phase in that no reference was made to the practice of physiotherapy and massage under the advice or guidance of the medical profession.

Certain representations were made by licensed physiotherapists in Winnipeg, and on Thursday, the 18th of March, this Bill was withdrawn.

All of which is respectfully submitted.

Ross H. Cooper,
Chairman.

Report of Committee on Constitution and By-laws

To the President and Executive of
The Manitoba Medical Association:

36.

Certain proposals (attached) for revising the Constitution of the Manitoba Medical Association have been received by your committee. These have been carefully reviewed and it has been found that none of the proposed changes is at a variance with any article of the Constitution other than those which they are specifically intended to amend.

Respectfully submitted.

Murray Campbell,
Chairman.

Report of Committee on Maternal Welfare

To the President and Executive of
The Manitoba Medical Association:

37.

Your committee begs to report as follows for the year 1947:

The maternal death rate was 1.1 per 1,000 live births (there were 20,681 live births in 1947), and is the lowest yet recorded for this Province. The figure for 1946 was 1.7, and for 1945 1.9.

The causes of death were as follows:

1.	Pulmonary Embolus	3
2.	Septic Abortion	4
3.	Toxemia of Pregnancy	3
4.	Hemorrhage	4
5.	Puerperal Sepsis	4
6.	Obstetrical Shock	2
7.	Other causes	4
	Total	24
8.	Associated maternal deaths	2

The causes of death in No. 7 were:

1. Paralytic ileus following Caesarian Section for disproportion.
2. Acute dilatation of the stomach.
3. Massive retroperitoneal hemorrhage.
4. Cerebral hemorrhage.

The causes of death in the associated cases were:

1. Pulmonary tuberculosis.
2. Acute ulcerative colitis.

38.

The case records in the possession of the Division of Statistics, Department of Health and Public Welfare, were carefully gone over. The following facts were considered to be of particular interest and importance:

1. Residence in city—11. Of these, 1 died at home and 10 in city hospitals.
   Residence rural—12. Of these, two died at home, 5 died in rural hospitals, and 5 in city hospitals.
   3 resided in Indian Reserves. Of these, 2 died at home, and 1 in a Sanatorium.
2. Autopsies were performed in 10 cases 38.5%
   There was no autopsy in 16 cases 61.5%
   15 women died in city hospitals.
   There were autopsies in 8 of these cases 53.3%
   There was no autopsy in 7 cases 46.7%

In these seven city hospital cases in which autopsies were not done your committee is of the opinion, after studying the available histories, that autopsies were necessary in all of them for a more satisfactory understanding of the causes of death.

Your committee urges all physicians associated with maternal death cases to give further committees all the help possible by answering all the questions in the Department's inquiry form, whenever possible, and to obtain permission for autopsy when post mortem examination is feasible.

All of which is respectfully submitted.

Cherry Bleeks,
Chairman.

Report of Editorial Committee

To the President and Executive of
The Manitoba Medical Association:

39.

During the past year we have produced twelve issues varying in size according to the amount of material available. This was less than we had hoped. There were no convention papers and very few from the Winnipeg Medical Society. Further, it was difficult to get the papers given at the various hospital luncheons. Dr. Whiteford, reporting from the Winnipeg General, did a most excellent job, but we had little from the other hospitals. We hope that this will be remedied in the coming year.

I wish to thank those who assisted me—Dr. S. S. Peikoff, who has been so very helpful, and Doctors S. Israels, Ruvin Lyons, D. W. Penner, T. A. Lebetter, E. L. Ross, J. M. McEachern and K. Borthwick-Leslie; and we all owe our thanks to those who have taken time to serve you as contributors.

We cannot express too strongly our appreciation of the work done by Mr. J. G. Whitley. His interest in the Review has led him to spare neither time nor effort in its behalf and to the advertisers we are beholden for the fact that they make the Review possible.

Respectfully submitted.

J. C. Hossack,
Chairman.

Report of Committee on Medical Education

To the President and Executive of
The Manitoba Medical Association:

40.

One meeting of this committee was held during the year, on February 10th, 1948, in the office of the Executive Secretary. Those present were Doctors L. G. Bell, T. E. Holland, B. Dyma, Alan Klass, and Eyjolfur Johnson. This meeting was called to discuss and reply to the questionnaire on Medical Education sent out by the World Medical Association.

The committee spent considerable time on those sections of the questionnaire dealing with Entry to Medical Courses, Clinical Teaching, Internship and Practice under Supervision. The majority of questions were of such a nature that only the Dean of the Medical School could answer them correctly so that the answers submitted by the Medical Faculty on questions of procedure and organization were accepted by the Committee on Education and included in their report.

Respectfully submitted.

L. G. Bell,
Chairman.

Report of Extra Mural Committee

To the President and Executive of
The Manitoba Medical Association:

41.

The following is a list of the meetings held during the year by the various District Medical Societies:

Brandon and District Medical Association

September 10, 1947, at Brandon:
- Dr. Maxwell Bowman—"Differential Diagnosis of Acute Anterior Poliomyelitis and Encephalitis."

October 8, 1947, at Ninette:
- Dr. Bruce Chown—"Rh Factor."
- Dr. H. Funk—"Common Foot Ailments."
- Dr. E. H. Dobbs—"T.B. and the General Practitioner."
- Dr. A. H. Povah—"Treatment of Tuberculosis by Streptomycin."

November 12, 1947, at Brandon:
- Dr. H. D. Kitchen—"Endocrine Dysfunction."
- Dr. W. S. Peters, Dr. J. A. Findlay and Dr. R. F. M. Myers—3 Case Reports.

June 17, 1948, at Brandon:
- Dr. D. N. C. McIntyre—"General Practitioners' Association of Manitoba."
- Dr. R. O. Burrell—"A Consideration of the Problem of Post-Thrombophlebitic Eczema, Induration and Ulceration."

Central District Society

No meetings.

Southern District Society

September 11, 1947, at Altona:
- Dr. A. B. Houston—"Tachycardia."

December 11, 1947, at Morden:
- Dr. K. R. Trueman—"Carcinoma of the Breast."
- Dr. S. A. Boyd—"Infant Feedings."

June 10, 1948, at Altona:
- Dr. D. L. Swartz—"Some Recent Developments in the Management of Urinary Infection."
- Dr. P. K. Tisdale—"Peptic Ulcer."

September 23, 1948, at Morden:
Dr. A. W. Andison—"Common Difficulties in the Management of Obstetrical Patients."
Dr. J. P. Gemmell—"The Management of Diabetes."

Northern District Society

November 28, 1947, at Dauphin:
Dr. R. Lyons—"Common Gynaecological Procedures."
Dr. S. Israels—"Treatment of Infantile Diarrhoea."

May 12, 1948, at Dauphin:
Dr. Gilbert Adamson—"Seizures."
Dr. E. S. James—"Low Back Pain."
Dr. J. S. Collings—"New Zealand Medical Plan."

North of 53 District Society

No meetings.

North Western District

September 10, 1947, at Russell:
Dr. B. D. Best—"Diagnosis and Management of Inertia."
Dr. M. B. Perrin—"Surgical Treatment of Duodenal Ulcer."

October 22, 1947, at Birtle:
Dr. A. R. Birt—"Common Skin Diseases."
Dr. A. Gibson—"The Mechanism of the Spine."

July 28, 1948, at Hamiota:
Dr. A. B. Houston—"Headache."
Dr. K. R. Trueman—"Diagnosis and Treatment of Gall Bladder Diseases."

During the year most requests for speakers have been made through the Association office and passed for action to this Committee. This procedure should be definitely encouraged.

Respectfully submitted.

A. R. Tanner,
Chairman.

Report of Committee on Credentials and Ethics

To the President and Executive of
The Manitoba Medical Association:

42.

Allow me to submit the Annual Report of the Committee on Credentials and Ethics.

The Committee consisted of three members, but the two meetings held during the year were attended also by the President of the Manitoba Medical Association and the Chairman of the Committee on Credentials and Ethics of the Canadian Medical Association.

Reference to the Committee of items of paid advocacy and the ethics of the formation of a drug manufacturing company in Western Canada with doctors holding preferred and common stock, opened a big question on which it was felt that the Canadian Medical Association should give guidance by a clearly enunciated policy.

43.

It had been anticipated that some clarification on the points in question might be forthcoming from the Annual Meeting of the Canadian Medical Association which was held in June, but none was received.

It would appear that uniform standards on questions of professional ethics should be well defined by the parent medical body in order that the provincial divisions may have some unity of action in the approach to such problems as the doctor's relation to the pharmacist or commercial houses in the sale of drugs, medical and surgical equipment and specialties, eyeglasses, etc., and drug stocks held in drug companies.

All of which is respectfully submitted.

I. O. Fryer,
Chairman.

Report of Group Insurance Committee

To the President and Executive of
The Manitoba Medical Association:

44.

Pursuant to the instructions of the Executive Committee of the Manitoba Medical Association, the Group Insurance Committee, composed of Drs. W. Boyd, Hartley Smith, M. Ranosky and myself, have studied the question of group insurance for the members of the Manitoba Medical Association.

After careful consideration and study of many plans, the Committee formed the opinion that Life Insurance on a group plan should not be considered.

In connection with Sickness and Accident Insurance, the following plan submitted by the North American Life and Casualty of Minneapolis is hereby recommended. Their Head Office for Canada is situated at Electric Railway Chambers, Winnipeg, Manitoba. Many other plans have been considered and discarded in favor of this plan.

The plan provides indemnity for loss of Life, Limb, Sight, Speech and Hearing or weekly indemnity caused by accidental bodily injury and weekly indemnity in the event of sickness.

There is a choice of two indemnity amounts:

Plan	Accidental Death and Dismemberment Coverage	Accident and Sickness Benefits	Annual Premium	Semi-Annual Premium
I	$1,000 Principal Sum	$50.00 wkly.	$78.50	$40.75
II	$1,000 Principal Sum	$60.00 wkly.	$94.40	$47.70

Note: It is possible to purchase extra Principal Sum Insurance at an additional premium of $1.50 annually per $1,000.00—but in no case to exceed $5,000 of such coverage.

45.

Optional Medical Reimbursement Coverage

Medical Reimbursement Coverage is available providing for the payment of expenses as a result of an accident for hospital, nurses, medical or surgical treatment. Cost of $500.00 of medical reimbursement is $10.00 annually, cost for $1,000 medical reimbursement is $15.00 annually.

Enrolment

The coverage described is available to all members of the Association actively engaged in their profession up to the age of 65, with the exception of female members who are entitled to coverage under special plans, namely:

Accidental Death and Dismemberment Coverage	Accident and Sickness Benefits	Annual Premium
$1,000 Principal Sum	$20.00 Weekly	$31.80
$1,000 Principal Sum	$25.00 Weekly	$40.80

Any member of the Association is entitled to coverage without medical examination and regardless of previous illness, but must not be disabled at the time of enrolment. The policy cannot be restricted nor endorsed for any specific illness.

If the plan is approved, there will be an initial enrolment period of one month. Following this, practising physicians who apply will be insured only on the basis of medical insurability. New graduates, however, will be allowed to enroll without evidence of medical insurability for one month after they obtain their license.

The plan becomes effective on the date applications are obtained from not less than fifty per cent (50%) of the eligible members of the Association.

46.

Cancellation of Coverage

The Company reserves the right to decline the renewal of the policy on the following grounds only:

1. Non-payment of premium.
2. When the insured member attains age 70.
3. When the insured member retires or ceases to be actively engaged in his profession.
4. If the insured member ceases to be an active member of the Manitoba Medical Association.
5. If subscribers to the insurance are less than fifty per cent of the Manitoba Medical Association membership.

The Company cannot cancel an individual policy except for the reasons outlined above. However, they reserve the right to cancel the entire group coverage at the renewal period upon giving sixty days' notice to the Manitoba Medical Association.

Following are the details of the times and periods for reimbursement:

47.

Death, Dismemberment, Loss of Sight, Speech or Hearing

If such injury shall, within twenty days after the date of the accident, wholly and continuously disable and prevent the Insured from performing any and every duty pertaining to his or her occupation and during the period of such disability and within One Hundred and Eighty days from the date of accident, result in any one of the following specific total losses, the Company will pay the sum set opposite such loss, provided further, that not more than one of these sums, the greater, will be payable for injuries resulting from any one accident, and in addition thereto will pay the Accident Indemnity as provided in Part describing the weekly indemnity for loss of time, between the date of accident and date of such loss.

For Loss of:	The Principal Sum
Life	
For Loss of:	Weekly Indemnity for
Both hands by severance at or above the wrist joint	260 Weeks
Both feet by severance at or above the ankle joint	260 Weeks
One hand and one foot by severance at or above wrist or ankle joint	260 Weeks
Speech and Hearing, if entire and irrecoverable	260 Weeks
Entire Sight of Both Eyes, if irrecoverably lost	260 Weeks
Entire Sight of One Eye, if irrecoverably lost, and loss of One Hand or One Foot by severance at or above the wrist or ankle joint	260 Weeks
Either Hand by severance at or above the wrist joint	130 Weeks
Either Foot by severance at or above the ankle joint	130 Weeks
Speech or Hearing, if entire and irrecoverable	130 Weeks
Entire Sight of One Eye, if irrecoverably lost	130 Weeks

48.

Weekly Indemnity for loss of Time Caused by Accident

If such injury shall, within twenty days after the date of accident, wholly and continuously disable and prevent the insured from performing any and every duty pertaining to his or her occupation and if the Insured be regularly attended by a legally qualified physician or surgeon other than himself, the Company will pay weekly indemnity at the rate specified for the number of days commencing with the first day of disability, but for a period not exceeding two hundred and sixty weeks of disability for any one accident.

49.

Weekly Indemnity for Loss of Time Caused by Sickness

If such sickness shall wholly and continuously disable and prevent the Insured from performing any and every duty pertaining to his or her occupation and if the Insured be regularly attended by a legally qualified physician or surgeon other than himself, the Company will pay Weekly Indemnity at the rate specified for the number of days commencing with the Fifteenth day of disability for a period not exceeding one hundred and four weeks of disability for any one sickness.

50.

Aerial Passenger Injuries

The Company will pay indemnity for any loss specified in the policy resulting from injuries caused by any of the hazards of air commerce while the Insured is riding as a fare-paying passenger in a licensed commercial aircraft for passenger service and while operated by a licensed transport pilot and flying on a regular air route between two definitely established airports.

51.

Exclusions and Reductions

The Insured shall not be entitled to indemnity for two disabilities at one and the same time, resulting respectively from sickness and accident. This insurance does not cover death, disability or other loss, sustained by the Insured while in or on, or attempting to get in or out of any vehicle or mechanical device for aerial navigation except as provided in Part "Aerial Passenger Injuries"; or caused by war or any act of war or sustained by the Insured while in military or naval service of any country at war, and in the latter event the unearned premium will be returned to the Insured.

In our opinion, the plan has the following advantages over any other plan submitted:

1. It only requires 50% of the members to subscribe to the insurance. All other schemes require at least 75%.
2. It pays for pre-existing conditions.
3. It is individually non-cancellable.
4. It is renewable to the age of 70, without increase in premium as age increases.
5. It does not require house confinement.
6. It cannot be restricted nor endorsed after issuance.
7. The coverage is 2 years for sickness beginning at 15th day of disability and 5 years for accident beginning at the first day.

52.

In conclusion, may we state that the Manitoba Dental Association have had a similar but not identical plan in operation since October, 1947. Their representative has assured us that they are perfectly satisfied with any claims that have so far been submitted. The Dental Group is with the same Company and underwritten by Mr. Wm. E. Brunning, Chief Agent for Canada, who has also made this proposal to us.

This report has been submitted to the Executive Committee of the Manitoba Medical Association and has been approved by them. A specimen policy has been submitted to the Legal Adviser to the Association and has been approved by him.

Therefore, the Committee has no hesitation in recommending this plan for the consideration of the members of the Association at their Annual Meeting, October, 1948.

Respectfully submitted.

L. R. Pabson,
Chairman.

Report of Committee on Historical Medicine and Necrology

To the President and Executive of
The Manitoba Medical Association:

53.

Your Committee begs to report as follows:

The following members of the Manitoba Medical Association have passed away since the last Annual Meeting:

Doctors H. William Riley, August Blondal, George Harold Carlisle, John Ralston Davidson, Frederick James Hart, Henry Harris Hutchinson, William John Moore McFetridge, Samuel James Elkin, George Forrest Weatherhead, E. W. Montgomery, William Lawson Mann, and John Douglas McQueen, all of Winnipeg.

Doctors S. W. Arthur, Portage la Prairie; James Winter Cartmell, Glenboro; Armand Landry, St. Jean Baptiste; Andrew E. McGavin, Carman, and Alfred Brodie Stewart, Plumas.

Respectfully submitted.

Athol R. Gordon,
Chairman.

Report of Post Graduate Committee

To the President and Executive of
The Manitoba Medical Association:

54.

The Post Graduate Committee of the Faculty of Medicine met twice in the past year and has considered the possibility

forming a Post Graduate Faculty in conjunction with the culty of Medicine. This is still in the committee stage and, r its fulfilment, will require acquiescence of the Board of overnors of the University and a budget authorized by the niversity. The report of the ad hoc committee to the Post raduate Committee of the Medical Faculy is in the process being submitted at the present time.

All of which is respectfully submitted.

A. Hollenberg,
Chairman.

Report of Fee Revision Committee

the President and Executive of
The Manitoba Medical Association:

At the Annual Meeting in 1946 a resolution was passed questing the Manitoba Medical Service to make Plan "B" vent. Following this, Dr. E. S. Moorhead, who was Medi- Director of the Manitoba Medical Service at that time, ld several luncheon meetings with members of the Manitoba edical Association, to adjudicate accounts. It was found at Plan "B" was still not solvent.

In 1947 the Manitoba Medical Service appointed a com- ittee, composed of Doctors C. K. Bleeks, C. W. Clark and Dyma, to meet with a committee from the Manitoba Medi- Association, Doctors A. Hollenberg, W. J. Boyd and P. H. cNulty. At the first joint meeting of the committees, Dr. cNulty was appointed chairman.

The Manitoba Medical Service presented a number of est ons on which they requested advice, especially that of anging fees, and the interpretation of the Minimum Fee hedule.

Four meetings in all were held, and at each of these Dr. T. Macfarland, Dr. J. C. MacMaster and Mr. A. G. hardson attended as guests.

The questionnaire of the Manitoba Medical Service was lly completed; then it was felt that this joint committee ould receive a questionnaire from the members of the Mani- ba Medical Association at large.

In February, 1948, the Executive of the Manitoba Medical ssociation was advised that the General Practitioners' Associa- n was being formed and they were requesting one fee hedule across the board for Specialists and General Practi- ners. The committee felt that they could not handle such situation and that it should be referred to the Annual Meet- g.

I wish to take this opportunity to thank the members of s committee for their faithful attendance at all meetings, d for their helpful co-operation at all times. I do trust that s committee continues to carry on with the same personnel they now have a working idea of what is required and of at is still to be done.

Respectfully submitted.

P. H. McNulty,
Chairman.

Report of Committee of Representatives to Cancer Relief and Research Institute

the President and Executive of
The Manitoba Medical Association:

During the past year the headquarters of the Cancer Insti- e have been moved into a larger building at 442 William venue, the old Normal School.

One of the major activities, and one which is constantly panding, is the Institute's program of public education in the al areas of the Province. This work is spearheaded at the various women's organizations throughout the rural areas and as many meetings as possible are arranged with these groups. Moving pictures are shown and the group addressed by a Public Health Nurse and wherever possible by the local physician. The staff of the Institute have expressed their gratification for the support they have received by the physicians in the rural areas. During the past year, 470 different women's organizations co-operated with the Institute, which is a figure almost double that of five years ago.

59.

Rural biopsy service has been extended and the demand for this service has increased nearly threefold in the last five years. The demand for both the X-Ray and Radium services of the Institute has steadily increased and the number of rural patients treated has approximately doubled in the same period.

Within the past year the cancer registration, patient follow-up and statistical service has been extended, and this department is now studying the stages at which various conditions are diagnosed. At present there are 1960 patients being followed in the follow-up service and 95.3% of these have up-to-date reports. This information permits, amongst other things, an analysis of the stage at which various types of cancer are being diagnosed.

60.

During the year the Union of Municipalities has recommended to the Provincial Government that the Cancer Institute establish a prepaid cancer diagnostic service for residents of rural Manitoba. A similar request has been made directly to the Institute by the Women's Institutes. The advisability of such a plan is now under study by the Cancer Institute. Such a plan would require financial resources beyond the ability of the Institute to meet. During the past summer the Dominion Government has made funds available to the provinces for cancer diagnosis and treatment, provided the funds are matched dollar for dollar from provincial sources. If such money should actually become available, no doubt greater pressure will be put upon the Institute to make some definite recommendations.

Respectfully submitted.

A. M. Goodwin,
Chairman.

Report of Manitoba Division, Canadian Medical Association, Advisory Committee to Department of Veterans Affairs

To the President and Executive of
The Manitoba Medical Association:

61.

The members of this Committee are Doctors W. J. Boyd and A. R. Tanner, elected in 1947 for a two-year term; Doctors C. E. Corrigan and C. H. A. Walton, elected in 1946 for a two-year term; Dr. F. G. McGuinness, Chairman, elected in 1946 for a three-year period. Accordingly, two members will be selected this year for a two-year term, and the retiring members are eligible for re-election. Dr. M. T. Macfarland has acted as Secretary of the Committee since the inception.

62.

Only one meeting of the Committee was held during the current year when the statistics for the year 1947 were presented by Dr. J. L. Lamont, District Medical Officer, D.V.A., indicating that the sum of $120,173.29 was paid out to doctors for the treatment of approximately 11,020 cases under the "Doctor of Choice" plan.

The necessity of adequate clinical reports and prompt response to correspondence was stressed. Reference was made to a circular letter requiring veterans in need of hospital treat-

ment attending the nearest D.V.A. hospital; also to another outlining recoverable charges at the rate of $9.00 per day in the case of a small group of Class 9A cases (emergencies).

Several accounts were reviewed by the Committee, and were satisfactorily adjusted.

No major problems have arisen during the year.

Respectfully submitted.

F. G. McGuinness,
Chairman.

Report of Representative to Manitoba Sanatorium Board

To the President and Executive of
The Manitoba Medical Association:

63.

I beg herewith to present my report as your representative on the Sanatorium Board of Manitoba.

The objectives of the Board, through its various agencies are:

1. To discover new cases as early in the disease as possible.
2. To treat all new discoveries as promptly and effectively as possible.
3. To, eventually, rehabilitate such cases, physically, economically, and socially.

64.

(a) Provision for Survey

In 1947, 276,000 were x-rayed, and to date this year about 200,000. The incidence of tuberculosis among those x-rayed was about 1 in 3,000. In Winnipeg, out of a total of 114,637 x-rayed, 439 had evidence of disease, and, of these, 222 were new diseases and only 26 were considered to have active disease. The incidence among Indians is always greater than among Whites, and the rate now stands at 36.7 per 100,000 for Whites and Indians combined, while among Whites alone, the incidence is only 21.9 per 100,000.

65.

(b) Hospitalization

In Manitoba there are 750 beds available for the treatment of White people and 450 for the treatment of Indians. At present there seems to be sufficient beds to treat all new cases, but the alarming feature is the *serious shortage of nurses.* So acute is this shortage, that at the last meeting of the Sanatorium Board, a Committee was set up to study the problem and, if possible, to arrive at some solution. Incidentally, the death rate among Indians is appalling, about thirty times greater than among White people.

66.

(c) BCG

Vaccination with this is harmless, and provides some degree of protection to those who have not previously been infected (that is, those with a negative tuberculin test). Nurses with negative tuberculins are vaccinated in the Sanatoria in Manitoba, in the Mental Hospitals, in a number of the General Hospitals and also some medical students. A program of vaccination with BCG is also in progress among the Indians.

67.

(d) Routine Chest Films for Patients in General Hospitals

In connection with the proposed Federal grant for Tuberculosis, it is planned to set aside a certain amount for providing x-ray equipment and personnel so that all persons shall be routinely filmed on admission to these institutions. Besides being a case-finding project, it will serve as a protection to nurses and hospital personnel generally. It is hoped to make a start in the larger hospitals in the near future.

68

(e) Funds for Special Enterprises

In connection with the Federal grants, certain other objectives have been recommended:

1. Streptomycin for all Sanatoria patients requiring it.
2. Physicians' fees for post-sanatoria pneumothorax.
3. A full time bacteriologist to supervise and standardize laboratory work.
4. Scholarships to encourage medical students to specialize in T.B. work.

Respectfully submitted.

J. Roy Martin,
Representative.

Report of Editorial Board, C.M.A. Journal

To the President and Executive of
The Manitoba Medical Association:

69.

Your Committee begs to report that through scientific papers prepared for and published in the Journal of the Canadian Medical Association, Manitoba physicians have made valuable contributions. Since the last annual meeting of our Association the following members have contributed papers published in the C.M.A. Journal: Doctors G. L. Adamson, J. D. Adamson, A. W. Andison, B. D. Best, J. N. Edmison, J. N. Crawford, D. J. Fraser, J. M. Kilgour (2), D F. McRae, E. W. Pickard, H. V. Rice, K. R. Trueman, C. H. A. Walton, T. H. Williams, F. G. Allison, M. H. Campbell, R. F. Yule, H. B. Chown, J. McGillivray, A. Gibson, W. B. MacKinnon, C. Hunter, A. Klass, J. M. McEachern, D. W. Penner, P. H. T. Thorlakson, F. M. Walsh, D. M. Wardrop. Others have had papers accepted but not yet published.

The Editor of the Journal, Dr. H. E. MacDermot, favorably reviewed the recently published book by Lt.-Col. J. B. Hillsman entitled "Eleven Men and a Scalpel." We offer our congratulations to Dr. Hillsman on the success of his book.

Monthly news notes and obituary notices have been prepared for the Journal and have appeared in its columns.

The relationship between the Editor of the Journal and your Editorial Board has been most happy.

Respectfully submitted.

Ross Mitchell,
Chairman.

Report of Committee on Public Health

To the President and Executive of
The Manitoba Medical Association:

70.

As there were no meetings of the Committee on Public Health held during the past year, there is nothing to report.

Respectfully submitted.

Roper Cadham,
Chairman.

Report of Committee on Pharmacy

To the President and Executive of
The Manitoba Medical Association:

71.

As no problems were referred to the Standing Committee on Pharmacy, and no meetings held during the past year, there is nothing to report.

Respectfully submitted.

C. H. A. Walton,
Chairman.

Report of Committee on Nutrition

To the President and Executive of
The Manitoba Medical Association:

72.

As during the past year no matters have been referred to the Committee on Nutrition, there is nothing to report to your Executive.

Respectfully submitted.

Harold Popham,
Chairman.

Report on Manitoba Medical Centre

To the President and Executive of
The Manitoba Medical Association:

73.

There were no meetings or activity of the Manitoba Medical Centre during the past year. Consequently, there is nothing to report.

Respectfully submitted.

W. G. Beaton,
Chairman.

Report of Committee on Epidemics

To the President and Executive of
The Manitoba Medical Association:

Re: Dominion Committee on Epidemics.

74.

There has been no call for action of any sort. In any case our Provincial Health Service is quite competent to handle any Epidemic, and my Committee would have to be re-vamped to be effective. I, therefore, beg to resign from the Chairmanship.

Respectfully submitted.

H. M. Speechly,
Chairman.

Report of Committee on Industrial Medicine

To the President and Executive of
The Manitoba Medical Association:

During the year 1947-48 no activities were carried out by the standing committee on Industrial Medicine.

Respectfully submitted.

Hugh Malcolmson,
Chairman.

Social News

Another October 30th wedding of interest was that of Frances Waugh, daughter of the late Dr. R. J. Waugh and Mrs. Waugh, 825 Somerset Avenue, Fort Garry, to Gordon Nichol Fasken of Toronto. The wedding was at 4 p.m. in Young United Church.

♦

I don't know how I ever missed it, but apparently M. R. MacCharles has been a Grandpa since July 13th. He doesn't even show it, in actions!

♦

My apologies to Geo. Denton Booth, Jr., for not congratulating him on his arrival ere this.

♦

Dr. and Mrs. Murray Campbell announce the birth of Harvey, October 9th. I got that one in time.

♦

Dr. and Mrs. F. J. E. Purdie also announce the birth of Frank, and Dr. and Mrs. Brian Murphy, their son, James Joseph.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1948		1947		TOTALS	
	Sept. 5 to Oct. 2,'48	Aug. 8 to Sept. 4,'48	Sept. 7 to Oct. 4,'47	Aug. 10 to Sept. 6,'47	Dec. 28,'47 to Oct. 2,'48	Dec. 29,'46 to Oct. 4,'48
Anterior Poliomyelitis	45	44	57	327	101	563
Chickenpox	72	60	46	28	2089	914
Diphtheria	1	5	2	4	19	69
Diphtheria Carriers	1	0	0	0	5	16
Dysentery—Amoebic	0	0	0	1	0	1
Dysentery—Bacillary	1	0	0	0	11	7
Erysipelas	4	2	2	3	27	35
Encephalitis	2	1	11	53	4	78
Influenza	3	5	6	14	123	152
Measles	26	66	62	86	833	6617
Measles—German	0	1	0	0	34	32
Meningococcal Meningitis	2	0	3	2	13	14
Mumps	101	69	29	21	1501	1225
Ophthalmia Neonatorum	0	0	0	0	0	1
Pneumonia—Lobar	3	17	4	11	128	166
Puerperal Fever	0	0	0	0	1	3
Scarlet Fever	14	13	16	5	176	158
Septic Sore Throat	1	5	0	0	21	14
Smallpox	0	0	0	0	0	0
Tetanus	0	1	1	1	4	5
Trachoma	0	0	0	0	1	2
Tuberculosis	58	190	148	216	1052	1443
Typhoid Fever	3	1	2	0	9	7
Typhoid Paratyphoid	0	2	0	0	2	0
Typhoid Carriers	0	0	0	0	0	1
Undulant Fever	0	1	0	1	11	7
Whooping Cough	24	32	81	98	266	982
Gonorrhoea	120	123	128	198	1185	1552
Syphilis	32	31	43	36	380	458
Diarrhoea and Enteritis, under 1 yr.	12	15	12	9	139	147

Four-Week Period September 5th to October 2nd, 1948

DISEASES (White Cases Only) *Approximate population.	*743,000 Manitoba	*906,000 Saskatchewan	*3,825,000 Ontario	*2,962,000 Minnesota
Anterior Poliomyelitis	45	15	102	334
Chickenpox	72	68	250	....
Diarrhoea and Enteritis	12	....	....	....
Diphtheria	1	1	13	2
Diphtheria Carrier	1	....	....	....
Dysentery—Amoebic	....	....	2	4
Dysentery—Bacillary	1	....	1	3
Erysipelas	4	1	3	....
Influenza	3	....	32	....
Infectious Jaundice	....	....	4	....
Malaria	....	....	....	4
Encephalitis	2	8	....	1
Measles	26	26	163	8
Measles, German	....	10	26	....
Meningococcal Meningitis	2	....	4	2
Mumps	101	29	183	....
Pneumonia Lobar	3	....	....	....
Scarlet Fever	14	12	83	48
Septic Sore Throat	1	....	1	....
Tetanus	....	1	....	....
Tuberculosis	58	31	101	230
Typhoid Fever	3	4	5	4
Typh. Para Typhoid	....	....	3	1
Undulant Fever	....	1	6	9
Whooping Cough	24	46	68	24
Gonorrhoea	120	....	340	....
Syphilis	32	....	133	....

DEATHS FROM REPORTABLE DISEASES

For Four-Week Period September 8th to October 5th, 1948

Urban — Cancer, 53; Pneumonia Lobar (108, 107, 109), 3; Pneumonia (other forms), 1; Poliomyelitis, 2; Syphilis, 1; Tuberculosis, 7; Diarrhoea and Enteritis, 4; Hodgkin's Disease, 1. Other deaths under 1 year, 18; Other deaths over 1 year, 187. Stillbirths, 20. Total, 225.

Rural—Cancer, 22; Influenza, 1; Pneumonia Lobar (108, 107, 109), 2; Pneumonia (other forms), 6; Puerperal Septicaemia, 1; Tuberculosis, 10; Diarrhoea and Enteritis, 1; Septicemia, 1; Other diseases due to spirochetes, 1. Other deaths under 1 year, 10. Other deaths over 1 year, 163. Stillbirths, 7. Total, 180.

Indians — Pneumonia Lobar (108, 107, 109), 2; Pneumonia (other forms), 1; Tuberculosis, 6; Dysentery, 1; Diarrhoea and Enteritis, 1. Other deaths under 1 year, 2. Other deaths over 1 year, 4. Stillbirths, 1. Total, 7.

♦

Poliomyelitis although not considered to be in epidemic proportions in Manitoba has been more prevalent than usual and has caused some residual paralysis. This disease has been epidemic in Minnesota this year.

Diphtheria has been at its lowest ebb in Manitoba's history. Immunization is paying dividends at last!

Typhoid Fever with three cases, all sporadic, shows a slight increase. The cause of two of these has been shown to be carriers. One carrier had the disease five years ago and the other twenty years ago.

Gonorrhoea and Syphilis both show definite decreases in the yearly figure to date. Penicillin treatment has been a wonderful boon in reducing inefectivity.